

# Health and Power to People

— theory and practice of Community Health



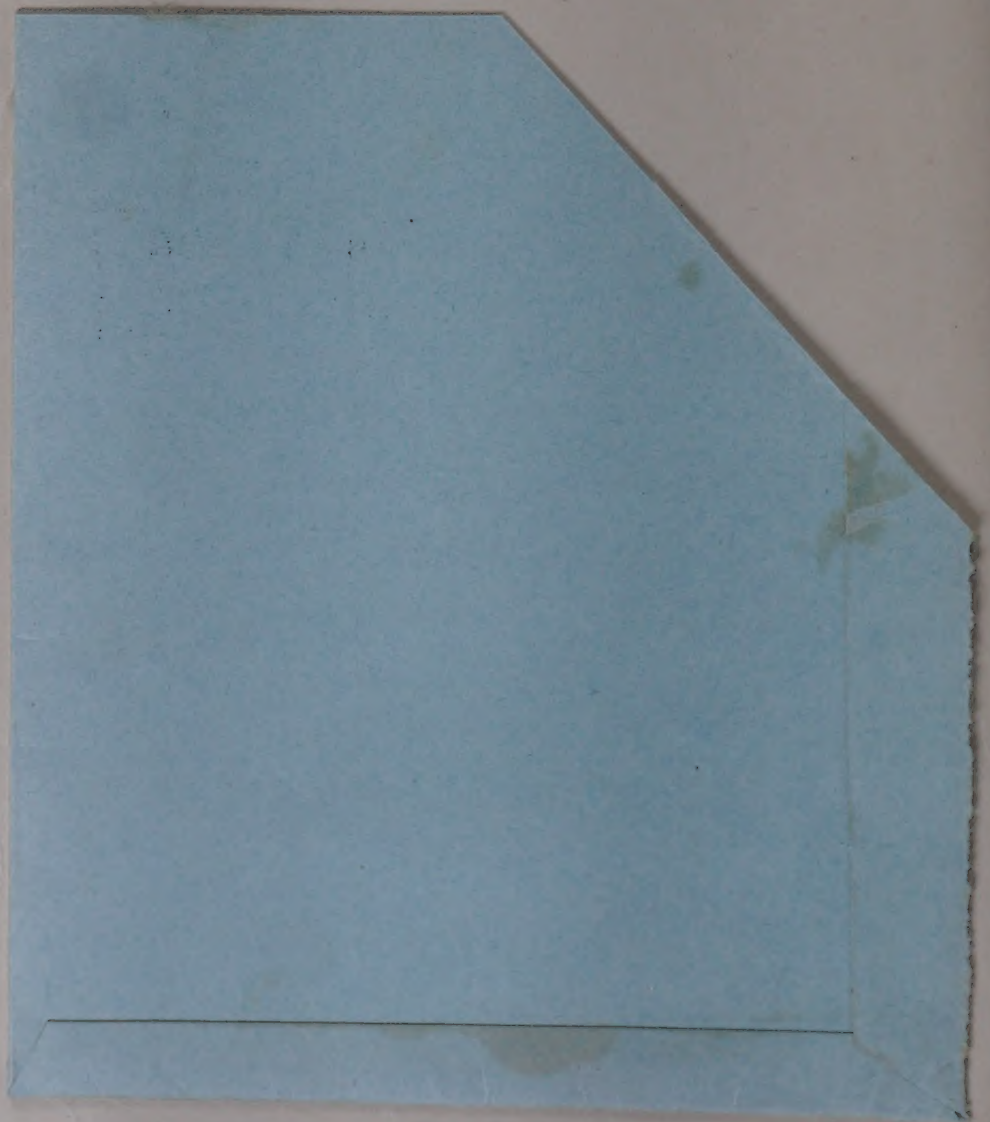
Community Health and Development Team (CHAI)

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# Health and Power to People

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COMMUNITY

Community Health and Development Team (CHAI)



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COMMUNITY HEALTH CELL

326, V Main, I Block

Koramangala

Bangalore-560034

India

01935

COMM 300

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# contents

## I Theory of Community Health

|                                                                  |    |
|------------------------------------------------------------------|----|
| community health — an idea whose time has come<br>abraham mathew | 5  |
| many many ways of community health<br>fr. thomas joseph          | 12 |
| faith — a unique dimension<br>sr. mariamma antony, f.m.m.        | 24 |
| a different kind of training—simone liegeois                     | 27 |
| from trainees to trainers —sr. jayaseeli f.m.m.                  | 33 |
| programmes, more programmes                                      | 37 |

## II practice of community health

|                                                                        |    |
|------------------------------------------------------------------------|----|
| bodokhoni — bringing people together<br>fr. chacko paruvanani          | 39 |
| pachod — management as redistribution of power<br>dr. ashok dayalchand | 45 |
| a new kind of rehabilitation workers — david morley                    | 57 |
| raha — many ways of tribal participation<br>fr. charles van besouw     | 58 |
| palmera — presence among the poor<br>sr. conrad mary                   | 66 |
| puthurvayal — herbal power<br>fr. joseph chittoor and sr. innocent     | 72 |
| philippines — basic communities at health work<br>fr. thomas joseph    | 78 |



## Bridging a gap

Define Community

We shall not.

Who is your neighbour? Ask the Samaritan.

Define Health

We shall not.

Those who have it do not care

Those who do not have health

Well, definitions, do not do any good to them, either

Between the health haves

and

the health have nots

There is a yawning gap.

Bridging this gap is what the following pages are all about.

Community health is the art of enabling people

to know more

to do more

and

to demand more



# Community Health—an idea whose time has come

Abraham Mathew is a member of CHAI's Community Health and Development training team.

"Let there be projects" they said, And there were Community Health projects. Doctors started them. Non doctors started them. It was the 70s. Not unlike Milton's paradise all these projects had one thing in common perception of the chaos that existed. The health care system they said, has been highly

medicalized  
institutionalised  
professionalised and  
profit oriented

It was Teihard de Chardin who said "No force on earth can stop an idea whose time has come."

And health has come to be used as synonymous with medicine and health care as synonymous with doctors, drugs and hospitals, (Ravi Narayan 1985).

Two high powered national academic bodies summed up it all. The Indian Council of Social Sciences Research (ICSSR) and the Indian Council of Medical Research in their study "Health for all" described the system as

- alien to the culture and traditions of the country and dependent on the West.
- curative oriented without preventive and rehabilitative approach
- expensive, catering to the needs of the rich
- non participatory from the part of the people
- with little analysis of the root causes of malnutrition and illness
- lacking the link between health and socio-economic development
- lacking educative element.

Alma ATA

Then came from Alma Ata, that unique expression of global apolitical will by 147 countries. The declaration defined health s'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.'

Health Policy

The National Health Policy of India also imbibed this spirit of WHO and relates health with social dimensions and



quoting the constitution of India it says that "The constitution of India envisages the establishment of a new social order based on equality, freedom, justice and the dignity of the individual. It aims at the elimination of poverty, ignorance and ill-health and directs the state to regard the raising level of nutrition and standard of living of its people and the improvement of public health as among its primary duties, securing the health and strength of workers, men and women, specially ensuring that children are given opportunities and facilities to development in a healthy manner." The policy documents recognizes that "the hospital based disease and cure-oriented approach towards the establishment of medical services has provided benefits to the upper crusts of society, specially these residing in urban areas, which "has been at the cost of providing comprehensive primary health care services for the entire population. . . . .". Speaking of the need for evolving a health policy it states that "It is necessary to secure the complete integration of all plans for health and human development with the overall national socio-economic development process, and specially in the more closely health related sectors, eg. drugs and pharmaceuticals, agriculture and food production, rural development, education and social welfare, housing, water supply and sanitation, prevention of food adulteration, maintenance of prescribed standards in the manufacture and sale of drugs and the conservation of the environment". It has to be "relevant to the actual needs and priorities of the community. . . . through the organized involvement and participation of the community. . . .".

**With one heart  
COR UNUM**

Almost at the same time, the Pontifical Council COR UNUM examined the new orientation of health services to fit in with the primary Health Care policy promoted by WHO. Speaking about the christian approach, the Encyclical 'Populorum Progressio' exhorts that "We must work for the overall development of each man and focus on the sick person rather than on his sickness. . . . We must turn our attention towards the human community of the patient, his family first, but also his neighbourhood and village. . . . . Since christians are the leaven, we must reach out towards the masses by providing simple, accessible and promotional health care according to our own possibilities, modest as they are, or in conjunction with the public services where this is allowed. Let us ever be mindful of the fact that service to the sick begins and continues to operate through the patients' human environment. Community health care is therefore, part of the comprehensive pastoral work of the church."



## **Catholic bishops speak up for the poor**

Taking a definite stand in favour of the poor in its various apostolates, the CBCI also resounded the echo of the call made by the papal document. Statement of the Catholic Bishops conference of India in 1983 reads like this. "The creative struggle of the people to bring about a just society invites us to enter into critical collaboration with people of all religions, ideologies and agencies who strive after a just society. A meaningful participation in this struggle calls for

- (a) serious analysis of society with the tools of social sciences and in the light of faith;
- (b) taking definite and unambiguous stand on various issues.
- (c) initiating concrete action programmes for change".

Starting with illness oriented curative extension services and shifting to preventive approaches, many of these projects have taken up community development activities as agricultural improvement programmes, self employment ventures, cottage industries, housing and sanitation programmes and so on. An analysis of the root causes of illness (of the poor) coupled with a scientific analysis of the society have moved various projects on to awareness building and community organisation programmes as true answers for the reasons that perpetually keep people unhealthy. For details of these different approaches refer the article 'An overview of different Community Health Programmes in India — Models and Approaches'.

## **A training team is born**

It was in this historical context that CHAI started thinking about community health approach. It is only imperative that being an association of health care institutions, CHAI responded to the signs of the times. A department for the promotion of community health was set up by 1981 and after much discussions and deliberations at different levels, the CHD team of CHAI started taking up training and orientation programmes in community health in different parts of the country. The training programmes work for developing village health worker while the orientation programmes were for the priests and sisters.

## **Giving shape to a philosophy of community health**

After two years of involvement the team of CHD of CHAI came together to consolidate the ideas and experience to develop a better understanding and deeper insight into the concept of community health. The team members together



with some resource persons and some others representing other organisations had discussions, orientation and planning in two sessions lasting for ten days each in April and June 1983. Between the first and second sessions the CHD team members spent sometime to study some existing projects and also to study in detail the various documents from the church, Government and otherwise, dealing with Community Health. At the end of the deliberations the statement that is brought out, which forms the philosophy of community health as envisaged by CHAI, reads as follows :

In the light of WHO's call to "Health for all by 2000AD", the revised National Health Policy of the Government and in line with the document by Pontifical Council Cor Unum on "the new orientation of health services with respect to primary healthcare", the teaching of the Church and the recent Popes and the statement of the CBCI from time to time, the community health department of CHAI upholds that :

Health is the total well-being of individuals, families and communities as a whole and not merely the absence of sickness. This demands an environment in which the basic needs are fulfilled, social well-being is ensured and psychological as well as spiritual needs are met. Accordingly, a new set of parameters will have to be considered for measuring the health of a community such as the peoples' participation in decision making, absence of social evils in the community, organising capacity of the people, the role of women and youth in the field of health and development etc., other than the traditional ones like infant mortality rate, life expectancy, etc.

#### **A new set of parametres**

The concept of the community health here should be understood as a process of enabling people to exercise collectively their responsibilities to maintain their health and to demand health as their right. Thus, it is beyond mere distribution of medicines, prevention of sickness and income generating programmes.

In a country like India, so vast and varied, where 80% of its population live in the rural areas and about 90% of the country's health care system caters to the needs of the urban minority, a new orientation and re-thinking of the whole health care system is the need of the hour.

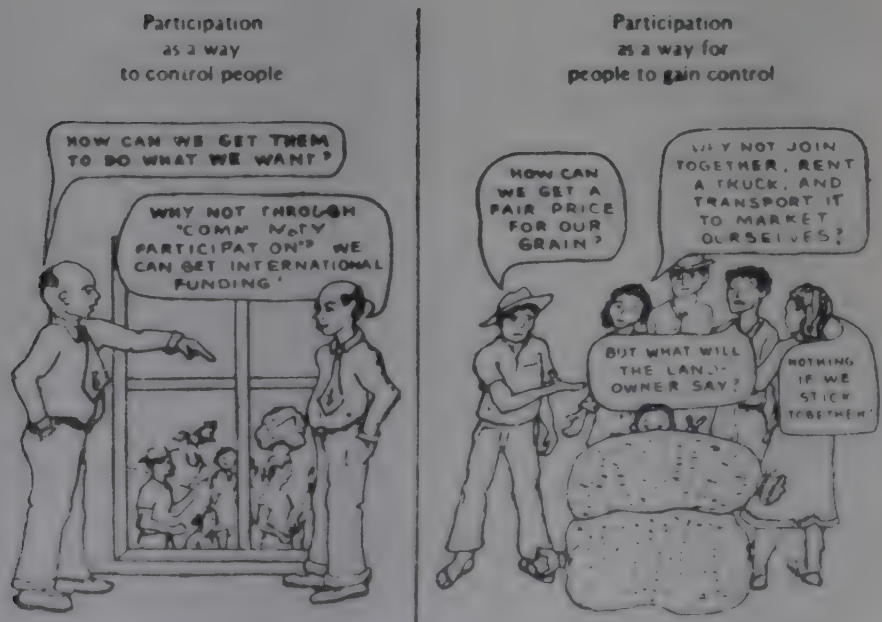


Putting people before profits

The present medical system with undue emphasis on curative aspect tends mainly to be a profit-oriented business. It concentrates on 'selling health' to the people and is hardly based on the real needs of the vast majority of the people in country. The root causes of the illness lie deep in social evils and imbalances, to which the real answer is a political one, understood as a process through which people are made aware of their real needs, rights, responsibilities and the available resources in and around them and get themselves organized for appropriate actions. Only through this process can health become a reality to the vast majority of the Indian masses.

Regarding our option : In the light of this vision and philosophy, we identify the exploited and the unorganised masses, the rural in particular as our target group. We intend to reach these groups through the existing health institutions in the country, especially through the member institutions of CHAI and other individuals and groups engaged in the field of people-oriented programmes, so that our motto of "HEALTH FOR MANY MORE" would be realized. In this process, possibilities of collaboration with other voluntary organisations which uphold similar philosophy and objectives will be explored to the maximum.

Picture from H.H.W.L.





## Health for many more

Obstacles can be handled in different ways:

Illustration from HHWL



Smaller obstacles we can sometimes  
remove, or overcome.



But larger obstacles we may need  
to work around—at least at first.

According to the vision and philosophy that has been stated above, the achievement of health for all and the practice of community health have much to do with the structures and systems of the society. It has to be a movement initiated at the grass roots aimed at transforming the structures and systems that make people unhealthy. This is the political dimension of the community health work. In this context, the word political means that which is pertaining to power distribution and decision making in the society. The poor are powerless. Community health is process of empowering people through awareness building, conscientization and organisation, so that people can collectively exercise their responsibility to maintain their health and to demand that as their right. Formation of people's bodies like village committee, farmers association, youth forums, mahila mandals etc. is a constitutive and essential element in this approach.

Healthy people from  
unhealthy Structures ?

Health for and by the people cannot become a reality in a society that is unhealthy in structures and institutions. Here the relevant question is what health action constitutes the efforts at finding solution to the root causes of illness. It should become a process of enabling people for transforming and creating appropriate structures and organisations so that the people can take control and responsibility for the decisions about how to mobilize, utilize and distribute services and resources.



Working for the creation of better health would also constitute a complementary role in raising awareness and organising the people. It has the potential of initiating a chain reaction starting with health issues and leading towards total social transformation. Thus struggling for justice in health is a lever for broad socio-economic and political changes.

CHAI has been trying to promote community health as a movement. Such an attempt has to look into two factors: that more and more groups share a common understanding on community health and that a net work is developed among those involved and interested in such approaches.

Speaking of community health projects existing in the country there are different approaches: One can find projects that basically do medical extension work. Then there are projects that concentrate on a planned distribution of health care facilities with preventive activities and economic improvement programmes. There are still other projects which with a comprehensive and analytical view of health and society, try to organise people as the possible radical answer to ill-health. The task for the future consists in initiating a dialogue among these groups leading towards a creative collaboration and linkage development. This is the concern that is expressed by many who are interested in people based health programmes. CHAI too shares this concern. The programmes and strategies of the organisation are being geared towards this end. Further, we would like our efforts to be shared and complemented by other groups and organizations-regional, national and international. This, we hope, would take us to even more meaningful and creative directions to make our involvements much more intensive as well as extensive.



# Many many ways of Community Health

## Introduction

Community health approach to health care has been widely recognized as the right alternative for ensuring health to the poor millions in developing nations. In India too, governmental as well as voluntary efforts are made for the promotion of community health.

In the evolution of health care system, this approach has emerged through a process of dialogue between the medical and the social sciences in an effort to make the health care system relevant and responsive to the sociopolitical-economic realities in the society.

Again, in the process of evolution and formulation of community health in terms of its principles, philosophies and methodologies, various models have been proposed and practised. In this paper an attempt is made to categorize these models into four, each with its own characteristic features.

Further, each model with its characteristics could be seen following a certain approach in community health. These approaches are broadly divided into three. An understanding of these three approaches could give us a frame work to assess the approach each model follows. Another interesting correlation is that each of these three approaches reflects a particular philosophy of development.

## Different Models

In the following paragraphs, an introduction is made into such an analytical overview. In the latter part of this paper the four models with their characteristics are listed out. Under each model, the particular approach into which it fits into is also given with certain indicators for assessment.

A study of the ongoing projects and the literature available on them reveals that in India there exists different models/types of community health projects. They fall under four major categories. Each one is run by different types of institutional setups as big hospitals, small hospitals, rural dispensaries, or non structured voluntary health/action groups. Again, each model is unique in terms of infrastructure services rendered, needs met, and the results achieved. It would be clear from the forthcoming table.



## Different Approaches

Three approaches have been identified in community health. They are : Medical approach, health extension approach, Comprehensive approach.

(a) *Medical approach* : Considers health as the absence of diseases brought about by medical interventions based on modern sciences and technology and medical and sees the role of the community (the people) as responding to the directions given by the medical professionals. It has its roots in the medical model of health care which believes that the eradication of ill-health depends on doctors and medicines.

(b) *Health extension approach* : Based on a critique of medical approach. It accepts WHO definition of health as the total physical, mental and social well being of individual. Mere advancement of medical technology and the sophistication of services would not bring health to the majority of the people — especially the poor — and that the approach should be a planned redistribution of health care facilities to reach the vastness of the society. The approach also advocates other socio-economic uplift programmes to enable people to benefit from health care facilities. Preventive care is also emphasized.

(c) *Comprehensive approach* : Views health, as total well being in the context of the situational realities of the individual. This concept is elaborated by stating that health, the state of total well being, is also a *human condition* which does not improve either by providing more services or mobilizing the community for providing more health services. It improves only by having the community take control and responsibility for decisions about how to mobilize, utilize and distribute services and resources. Here community is the subject, the decision maker. It is a process of conscientization\* organization and capacitation of the community for action. It has bearing on the social, economic, political and cultural dimensions of human life, in the sense that the approach strives to bring about changes in them so that there would emerge a society where human life would be more healthy in the complete sense of the word.

\*Conscientization is "an awakening of consciousness, the development of a critical awareness of a person's identity and situation, a reawakening of the capacity to analyse the causes and consequences of one's own situation and to act logically and reflectively to transform that reality" (David Millwood).

### Community Health and the Different Approaches to Development :

Development work is based on certain analysis of the backwardness of the people. According to the analysis, different philosophies of development work are arrived at. There are mainly three approaches: modernization approach, welfare approach, and social justice approach. In the context of



speaking about different approaches in community health work, it would be worth mentioning these approaches. It is interesting to note that reflections of these approaches are found in the three community health approaches.

### **Modernization**

(a) The modernization approach analyses poverty as the lack of enough production and it makes efforts to gear up production through advanced technology in the field of agriculture and industry. It believes that the result of modernization would trickle down to the lower strata of society.

### **Welfare**

(b) The welfare approach recognizes different classes and castes existing in the society. It is due to the co-existence of development and under development in the society, and is accepted as a normal reality. Effects are made to alleviate the sufferings of the poor through organizing relief and charity work. People are passive recipients here. Recently there has been some changes in this approach and it recognizes the participation of the people and the mobilization of their resource. Programmes also have improved remarkably from relief work to development programmes aimed at the *uplift of the poor*, through income generating programme, literacy programmes, vocational training etc. The poor continues to exist and the disparity between the rich and the poor also continues as a reality. Statusquo is not disturbed.

### **Social justice**

(c) In social justice approach, a critical analysis of the society is employed and poverty and backwardness are understood as man made historical reality. The reasons are attributed to the various forces and the dynamic at work in the society. Poverty is perpetuated by injustice. Justice could be brought in only through a restructuring of the society. It could be achieved through empowering the people through awareness building and organization. Ultimate development of the poor would mean fair distribution of the means of production, living wages, consumption of good food, availability of public amenities, practice of human values as love, cooperation and unity.

It becomes clear that the analysis and approaches of development work has correlation with that of community health work. Characteristics of modernization approach are reflected in medical approach and features of welfare approach find expression in health planning approach. Social justice approach goes well with, comprehensive approach in terms of its analysis and approach.



Pic. from H.H.W.L.



## V. The Four Models and Three Approaches in Community Health

As mentioned already, the community health programme existing in the country could be classified into four based on its characteristics. The following table would shown that. Under each programme a note is made as to which approach of community health it belongs to. To make it clear six indicators are given based on which this assessment is made. These indicators are :

- role of health services,
- role of professional,
- role of community worker,
- community participation,
- evaluation and
- financial support.

For each approach these indicators show different explanations.



| <i>Type of institution/infras-<br/>tructure</i>                                        | <i>Nature of Services Rendered</i>                                                                                             | <i>Needsmet</i>                                               | <i>Result — Qualitative chan-<br/>ges.</i>                                                                                                                                      |
|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Capital intensive, highly so-<br>phisticated and institutiona-<br>lized big hospitals. | — Extension service from<br>hospital.                                                                                          | — Treatment of minor phy-<br>sical ailments.                  | — People become more<br>conscious about sick-<br>ness and medicines.                                                                                                            |
| Mobile medical team with<br>doctor and medicines.                                      | — Curative care.<br>— Running village clinics.<br>— Referral service, free<br>medicines.<br>— weekly or fortnightly<br>visits. | — Referral and free trans-<br>portation to the hospi-<br>tal. | — more patients in the<br>hospital<br>— feeling of dependence<br>in the people, demand-<br>ing free services.<br>— shift from home re-<br>medies and indige-<br>nous medicines. |

## B. THE APPROACH FOLLOWED

The approach followed is *medical approach*. The following are six indicators which would help us to make an assessment on that.

| <i>Indicators.</i>                 | <i>—Explanation.</i>                                                                                                                        |
|------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|
| a. Role of health service          | — means to improve the health status of the people                                                                                          |
| b. Role of Medical Professional    | — Key to the programme — manager, planner, problem solver,<br>coach, consultant, clinician, leader, teacher, evaluator.                     |
| c. Role of community health worker | — a means by which medical advances could be applied more<br>rapidly and effectively.                                                       |
| d. Community participation         | — a means to ensure more acceptability and utilization of services.                                                                         |
| e. Evaluation                      | — Based on analysis and interpretation of statistics which re-<br>flect the scope and results of applied medical science and<br>technology. |
| f. Financial support.              | — needed to create, expand and maintain the service.                                                                                        |



| <i>Type of institution/infrastructure</i>                               | <i>Nature of services rendered</i>                                                                           | <i>Needs met</i>                                                                      | <i>Results —</i><br><i>changes.</i>                                                 | <i>Qualitative</i> |
|-------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|--------------------|
| Capital intensive, sophisticated and institutionalised small hospitals. | — Extension services.<br>— curative and preventive care.                                                     | — Treatment of minor ailments.<br>— Referral and free transportation to the hospital. | — people meeting in groups.<br>— Learn some preventive methods.                     |                    |
| Medical team with or without doctor.                                    | — Village clinics<br>— Referral services.<br>— Medicines at reduced rates<br>— weekly or fortnightly visits. | — personal and environmental hygiene.                                                 | — More patients in the hospital<br>— Learn that they can do something about health. |                    |
|                                                                         | — Health Education                                                                                           |                                                                                       |                                                                                     |                    |
|                                                                         | — MCH programmes/immunization.                                                                               |                                                                                       |                                                                                     |                    |
|                                                                         | — Village Health Workers with medical kit.                                                                   |                                                                                       |                                                                                     |                    |

## B. APPROACH FOLLOWED

The approach followed is *Medical approach*, (But there are certain changes, in the sense that) however, it is not strictly Medical approach. There is an *inclination towards Health Extension* approach.

| <i>Indicators.</i>                       | <i>Explanation.</i>                                                                                                            |
|------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|
| a. Role of health services.              | — Means to improve the health status of the people.                                                                            |
| b. Role of medical professional          | — Medical professional continues to be the key personnel.<br>But, para medicals gain a role here.                              |
| c. Role of Community Health Worker (CHW) | — along with being a person to ensure more community acceptability for medicines CHW also imparts preventive health education. |



- a means to ensure more acceptability to medicines as well as a means to disseminate ideas of preventive health education.
- based on analysis and interpretation of health statistics that shows the scope and result of applied medical science as well as the effectiveness of preventive health education.
- needed to create, expand and maintain the service.

d. Community participation

e. Evaluation

f. Financial support

### MODEL III. A. CHARACTERISTICS

| Type of institution/infrastructure.                                                       | Nature of services rendered                                                                                                                                                                                                                                                                                                                                 | Needs met.                                                                                                                                                          | Results — | Qualitative changes.                                                                                                                                                                                                                                                         |
|-------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Rural health centres manned by nurses, not institutionalized, still very much structured. | <ul style="list-style-type: none"> <li>— Preventive, promotive and curative.</li> <li>— Community health workers with simple medicines.</li> </ul>                                                                                                                                                                                                          | <ul style="list-style-type: none"> <li>— Better sanitation.</li> <li>— M.C.H. Services.</li> <li>— Supplementary income for a section of the population.</li> </ul> | —         | <ul style="list-style-type: none"> <li>— people become aware of the importance of preventive medical care.</li> <li>— Less patients to go to the hospital</li> <li>— Better child care.</li> <li>— people try to see health in relation to economic backwardness.</li> </ul> |
| A team composed of a nurse and social workers.                                            | <ul style="list-style-type: none"> <li>— Health education, Adult Education</li> <li>— Small income generating projects.</li> <li>— kitchen garden</li> <li>— M.C.H.</li> <li>— Collaboration with govt and other agencies.</li> <li>— village meetings and discussions on different village problems.</li> <li>— promotion of collective action.</li> </ul> |                                                                                                                                                                     | —         | <ul style="list-style-type: none"> <li>— Develop more interaction among the villages, formation of small informal groups, mahila mandals.</li> <li>— people become aware of their collective strength.</li> </ul>                                                            |



## B. APPROACH FOLLOWED

The approach followed is Health Extension approach. The following indicators would make it clear.

| <i>Indicators</i>                  | <i>Explanations</i>                                                                                                                                                                                                                                                               |
|------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| a. Role of health services.        | <ul style="list-style-type: none"><li>— It views that good health is the result of planned health services, experts from other fields as economists, social workers, etc are also involved to make services effective.</li></ul>                                                  |
| b. Role of medical professional    | <ul style="list-style-type: none"><li>— The medical professional is viewed as a component rather than key experts from other disciplines are also involved — economists, social workers, etc. Attempts are also made to include community leaders.</li></ul>                      |
| c. Role of Community Health Worker | <ul style="list-style-type: none"><li>— CHW is considered as an agent of change — and works as a multi purpose worker which include medical services, prevention, public health work, health education, nutrition education, food production and housing improvements.</li></ul>  |
| d. Community participation.        | <ul style="list-style-type: none"><li>— Participation of the community is considered important because it provides a resource base, a means to mobilize more resource — personnel, money and material. Mainly it involves the community leaders.</li></ul>                        |
| e. Evaluation.                     | <ul style="list-style-type: none"><li>— Concerned with assessing whether a programme with a variety of activities (ranging from health to economic development programmes) provides the most benefits in terms of health improvements for the least amount of resource.</li></ul> |
| f. Financial support.              | <ul style="list-style-type: none"><li>— Used to build small health centres and to generate community resources — man power, money and material. The programme has to be made selfsupporting.</li></ul>                                                                            |

| <i>Type of institution/infrastructure</i>   | <i>Nature of service Rendered</i>                                                                           | <i>Needs met</i>                                                 | <i>Results</i>                                                                               | <i>—Qualitative changes.</i> |
|---------------------------------------------|-------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|----------------------------------------------------------------------------------------------|------------------------------|
| Rural health centres/action-groups.         | — Services aimed at building healthy communities.                                                           | — Basic needs met by the people through their organized efforts. | — Participation and collective action of the people to build up a healthy community/society. |                              |
| Flexible and non structured.                | — Community diagnosis.                                                                                      | — Better services from the government.                           | — Increased self confidence and independence.                                                |                              |
| One team composed of a nurse and activists. | — Critical understanding of health and its relation to unjust social order.                                 |                                                                  | — faith in their own power to fight for a healthy society.                                   |                              |
|                                             | — Awareness building through non-formal education programmes.                                               |                                                                  | — Health is considered as a right and duty and at the same time seen as a political issue.   |                              |
|                                             | — Organizing the people for collective action.                                                              |                                                                  | — people struggling against social injustices.                                               |                              |
|                                             | — Exposing social illness.                                                                                  |                                                                  | — Cooperation among the people based on critical understanding of social realities.          |                              |
|                                             | — Formation of Action groups, Mahila mandals, youth clubs, village committees, Farmer's club, Trade unions. |                                                                  | — New forms of politics and new forms of peoples' movement.                                  |                              |
|                                             | — Demanding services from the Govt. from health as well as other departments.                               |                                                                  | — Alternative indigenous medical systems developed.                                          |                              |
|                                             | — Identifying and training village animators.                                                               |                                                                  |                                                                                              |                              |
|                                             | — Promotion of low cost and simple home remedies.                                                           |                                                                  |                                                                                              |                              |



In this model the *comprehensive approach* is followed. The following explanation would make it clear.

| Indicators.                        | Explanations.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| a. Role of health services.        | <p>— the concept of health is totally integrated into the socio-political fabric of the community. Hence health services are a part of a strategy (or an entry point) for development and a tool facilitating the process of community growth.</p>                                                                                                                                                                                                                                               |
| b. Role of medical professional    | <p>— Since the role of health service is to enable change in the existing social structures (to bring about equity of opportunities and services), the profession is viewed as a resource an enabler, educator and a stimulus. The community is the decision maker which defines the role of the professionals and the professional is accountable to the people.</p>                                                                                                                            |
| c. Role of community health worker | <p>— Community Health Worker (CHW) is an agent of change, an educator, a volunteer selected by the community. Uses health work primarily as a means of bringing about change in the attitudes and behaviours, and in the long run, social structures through health and development activities. Thus CHW works towards social justice and social, political and economic equality. CHW could be better called, <i>community level worker</i> (CLW) since the work is total development work.</p> |
| d. Community participation.        | <p>— Community participation is considered as a step which will help people gain control over their own lives by collectively working towards making the socio economic and political structures compatible with and conducive to health and development of the poor. It starts with awareness building and organization. Community is the decision maker in the community programme, and through such involvement they go through a process of learning to live together, think to-</p>         |

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gether and work together and take control of policies which affect their lives.

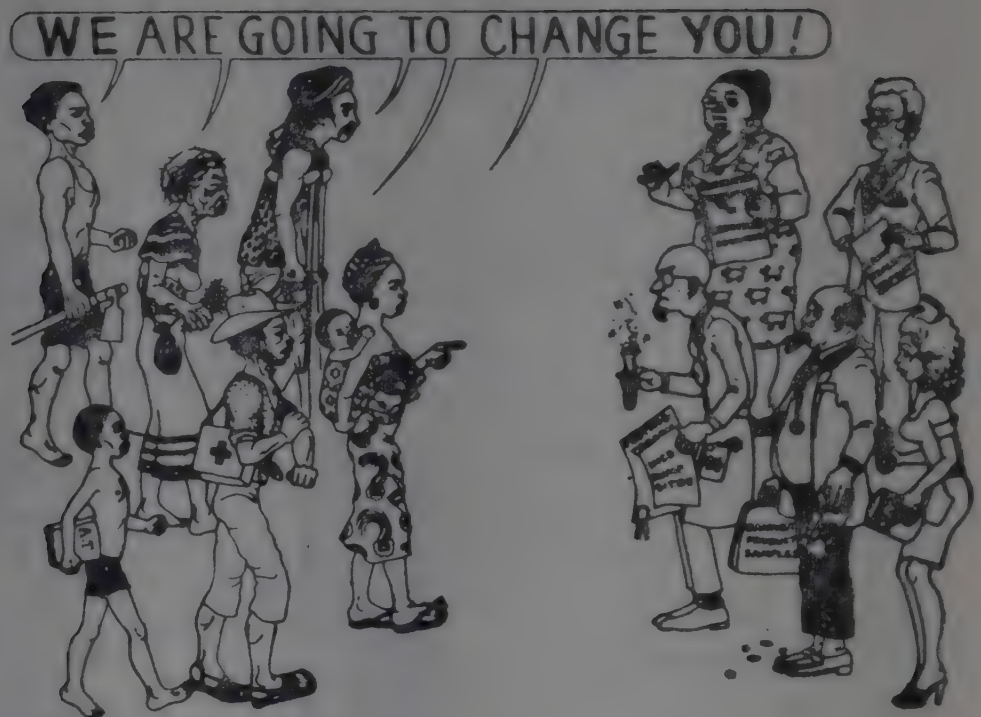
e. Evaluation.

- The community is the evaluator, — it is participatory evaluation methods-community decides on the objectives, priorities and methodologies of the process. The development worker, as an enabler helps the community and works with them. The evaluation itself is a tool and a method for community awareness, self determination and growth. In the entire process, stress is laid on the qualitative aspects and the efforts at bringing about changes in the existing health delivery system and the establishment of alternate models.

f. Financial support.

- To spark off a programme finance is needed. But the goal is to start a programme which is able to be sustained through community contribution and commitment not through outside finances. The investment is in education, rather than technology and expanded services. It also means money to identify and develop indigenous resources in terms of manpower, materials and support. (In terms of health aid, it looks for seed money). Maximum efforts are made to make use of government funds but not at the cost of allowing them to dictate terms. It should never hamper the community in its process of growth towards awareness and organization.
-





### Conclusion :

Community health is a term understood and interpreted in different ways by different people. This is due to the differences in the analysis of the ill health. Based on one's analysis the programme that is initiated would conform to a particular approach and philosophy.

This paper, we think, would help the implementors, of community health programmes as well as those who intend to start one to develop a still more reflective understanding. This understanding blended with our commitment to the poor would help us all, to make our involvement more meaningful.

## FAITH—A UNIQUE DIMENSION

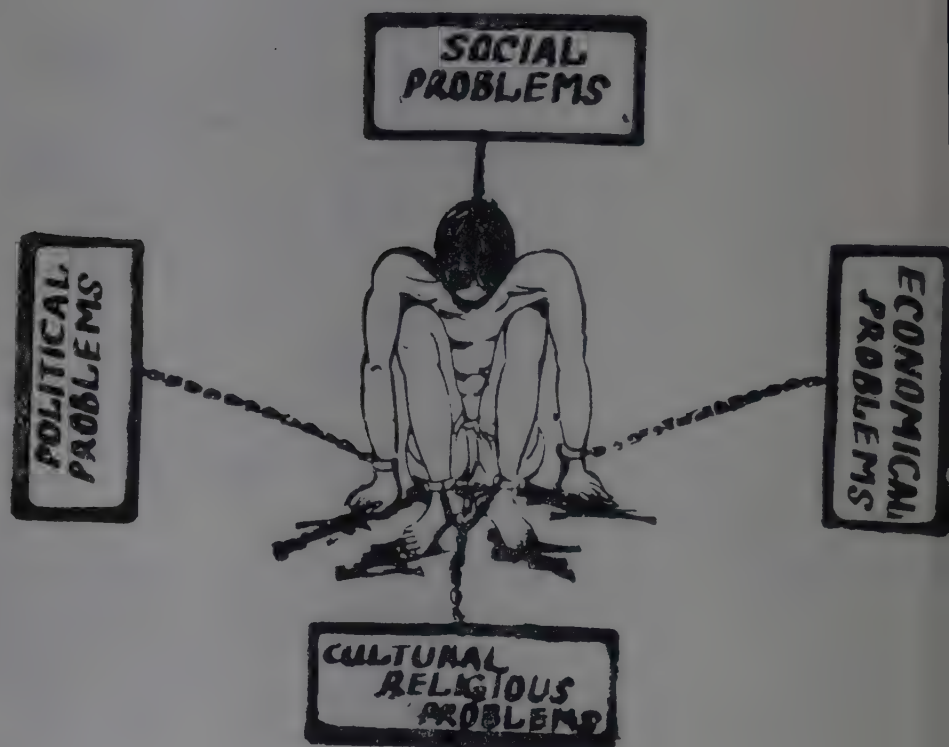
"If we are going to be full time workers in Health and development, our prayer life will suffer."

"Our vocation is for evangelization, not for social work like this"

"Our first responsibility is to fulfil the community needs"

We will not be able to be "committed religious".

"If we are going to the village regularly, our community life will be affected".



Comments of this tone are often echoed from various religious groups when the subject of full time work in the villages is discussed. Especially members of religious congregations are taken back at this suggestion.

There is always a note of caution attached to village work.

"You will have to be careful in doing social work, otherwise you will end up somewhere else".

Sr Mariamma Antony F.M.M is a member of CHAI/CHD team.

The above comments represent the attitude of a large number of the participants of various training programmes in Health and Development conducted by the CHD of CHAI. From 1983 CHD conducted various long term and short term training programmes and orientation courses in different parts of the country for different groups comprising of lay people,



religious sisters and Priests. Many have expressed their concern that the involvement in social activities will create problems regarding prayer and apostolate. These persons could not consider the village experience and prayer as a single entity. Hence the above reactions with these comments in mind, in all our training programmes, Eucharistic celebrations and biblical reflections are given much importance. Realizing the importance of the faith dimension, the best time of the day i.e. morning and evening is used for this exercise. This, our effort, has not been in vain as some of the participants have shared with us in the following lines.

Many came to a personal understanding of the proper perspective of evangelisation.

When these participants went with this personal conviction to work in the villages, they found,

## **PROCLAMATION OF TO THE POOR**



**THEY  
SEE  
HEAR  
SPEAK  
WALK  
LIBERATED  
SET FREE**

"The human and friendly attitude of the people gave a human dimension to my religious life". "I have built up confidence in myself and in the people. The village people with whom I work are not a threat but an inspiration to my committed life".

"Evangelisation means to build a mature society. Now I realised that Bible is deeply related to the life situation of the people with whom I work. It cannot be properly understood without the genuine involvement with the struggle, anxieties and the hopes of the people

"This helped me to articulate our spirituality through the need, desires and challenges of the people."

"Jesus is more concerned about the people who are weak and oppressed and therefore gospel has become the inspirations for my work."

"Our spirituality and charism is to live the Gospel among the poor. This training has helped me to make my religious life relevant. Now I realise that health and development work are part and parcel of my spiritual life and hence I have to be involved as a full timer."

"People and work became a source of inspiration to my prayer, life, people and work become my prayer life, Prayer and life became one unit."

The emphasis on faith and life reflection during the training courses have helped many religious sisters to relate full time village involvement to the religious community work.

"Now I feel that I continue the work of Jesus who went to the people and the work is truly in line with the charism of the congregation"

"Being with the people, developed positive attitude and conditions in my religious community and in the church (parish) at large and I understand my prophetic role better."

"Now my religious community understands the seriousness and relevance of village work. They have started supporting and co-operating with me".

The religious heads vouch for the renewed spirit and the conviction of the participants. In the words of a major superior,

"these sisters are taking back the congregation to the original spirit and work of the founding members and pioneers. They are actually involved in the village work."

A Bishop feels,

"These sisters are the "Promises" of the congregation, Diocese and church at large". From these feed back we have come to realise that this dimension which CHAI - CHD has named "Faith dimension" in our training programme has helped the participants to rediscover their vocation and the charism of the respective congregations.

CHAI-CHD consider the faith dimension as part and parcel of health and development activities because it is the motivating force for serious involvement with the people. This is also to help the people to integrate their spiritual life in their apostolate and to evolve a spirituality and life style which inspires support and strengthens their commitment.

Today, when we venture into new areas of mission work, which requires new attitude and life-styles, the traditional spirituality shows itself to be inadequate and nonresponsive to the growing challenges that we face in the new mission. In this new situation it is no use finding fault with the spirituality nor in making hectic efforts to adapt ourselves to the traditional spiritual exercise. We may have to look for new experiments which will give us the experiences of God in the reality we confront in everyday life.



## A different kind of Training

Simone Liegeois worked with the Voluntary Health Association of India, as a Community Health Consultant, from September 1974 to March 1984. Now, she works with the Damien Foundation, India.

It started in the fifties. Up to then health care has mainly been focused on treatment of diseases. Of course, there were already public health programmes including massive immunization programmes, sanitation improvement, disinfection of drinking water etc. But these were still exceptions and the majority of the medical institutions were just "treating patients". Suddenly, it was realised that such an approach would not improve the health status of the people as it did not deal with the roots of the diseases. Primary health care was born. Primary health centres were built all over the country, intensive programmes of control and eradication of specific diseases were developed. Since then we heard a lot about "primary health care", a "community health", health for all . . .

Twenty years later, it has to be recognised that Primary health care had not given the expected results. Why not? When planning and developing Primary health care prog-

Are you looking at Hailey's Comet ?

No I am looking for people





Vicious cycle of health care causing poor health

ramme, one important factor seemed to have been overlooked; THE PEOPLE. The People who were to benefit from these programmes somehow were passive, unconcerned, uninvolved. They had been left out of the planning, knew little of the aim of the programme and were not expected to participate actively in its implementation. Today, all concerned with People's well being, accept the concept that to be successful community related programme must be based on active participation of the People. "Work with the People not for them". . . and this means involve the People from the very beginning of a community related programme: the identification of the community problems, their importance for the community, the local interest and resources available to solve them, the joint effort to improve the situation by removing together the cause of the disease in the community.

Today, most of the health institutions understand the need of good community health programme to be attached to their institutions. In fact, many of them realise that their institutions' primary objective should be to be a referral treatment centre for Primary Health Care Programmes. But how do we develop good people based community health programme? This question was often thrown to me during my numerous visits to hospitals, dispensaries and small health centres all over the country. This is a question on which the Voluntary Health Association Of India reflected and worked for many years and where, with the help of my colleagues I learnt much. As early as 1975, V.H.A.I. started to get involved in Community Health Workshops and training programmes of different types. These programmes were regularly assessed and re-adjusted so as to meet the requirement of the participants. I want to share with you a few important points to be remembered by those who are involved in training Community Health Workers at all levels.

**Be clear of what we talk about**

Terms such as community health — public health — primary health care are generally used indiscriminately with no definition. The need for a conceptual clarification of these terms became clear to us in the very first workshop we organised. People have different meanings for some words. If we have to learn together, to discuss together, one of the first exercises we would have with the participants is a discussion on the meaning of terms such as health — community — community health — people's participation. A definition acceptable to all would then be worked out and thus the meaning of these terms would be similar to all.

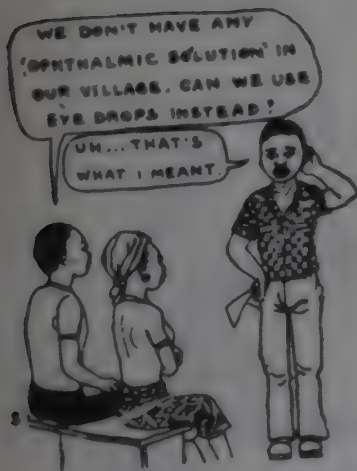


For example, generally the participants would conclude the discussion on health by telling that "health means a continuous process of harmonious living allowing for a person to develop his/her full human potential." This would include physical — social — economic — mental — psychological — spiritual well being. From there, community health would be defined as a "continuous improvement of harmonious living conditions, through collective efforts, so that each individual of the community would have a chance to live a human life".

### Terms like germs need polishing

With a clear understanding of these terms the participants would themselves conclude that community health programmes would have to include much more than what is generally considered as part of such programmes. They would readily understand the need to find out the true roots of the community's disease. Participants would often find out that roots are much deeper than it would superficially appear. For example, we found in several cases that shortage of clean drinking water supply was due to oppression or carelessness. Malnutrition is often found to be due to poor economic conditions. How can a Health Worker help to solve these problems? From the two examples mentioned here above two important points can be discussed:

- The Health Worker needs to work in coordination with other development agencies such as the Block Development Office, Agricultural development programmes, etc.
- If malnutrition is most often due to poor economic condition it becomes urgent for the health workers to re-think health and nutritional education programme. At this stage, participants are generally ready to discuss new approach for this: what cheap locally available food would be suitable for small children? How to prepare it so that it can easily be digested by a small child? How to prepare it easily so that it does not become an additional burden on the mother?



Source: HHWL

### Learn through our own experience

To make the matter more meaningful the different situations of the people and of the importance of Community Health are brought up in a practical way through case studies, role plays, out patient records analysis, local market survey practice, discussion with the people of the area where the training programme would be held. Participants would spend

several days, including the nights, in one village and through this would experiment daily life difficulties in the rural areas.

In one of our training programmes we could analyse we maintained out patients records and through this we found that:

- more than 90% of the diseases treated in the OP could have been prevented
- 90% of the diseases could have been treated at the level of a Para Medical Worker and out of these 60% could have been treated in the village itself by a non professional person or would not have needed treatment at all. Only 10% of the diseases would have required medical advice;

We also came to realise that, malnutrition, though so important for the children, is rarely considered as a "disease" and is not taken care of in an ordinary dispensary. Still in the same training, after making a market survey practice in the area, the group found out that the average family earned less than 2/3 of the minimum required by them to survive





**Let our heart speak louder  
than our head**

Group discussions, as a means to learn, are particularly meaningful. To liven the procedure several approaches can be used; small group discussion brought into a general discussion afterward, fishbowl discussion, panel discussion, debate with pro and con opponents. In such exercises, the function of the moderator is very important. He/she should support the participants, encourage them to express themselves freely and help them to reach their own conclusions. In no case should the amimator impose his/her own view.

Knowledge is important, but much more important is for the Community Health Worker to be able to empathy with the people and share his/her feelings with them. Many of the people's problems are such that it is often difficult for us to do anything about it. But people do feel and expect us to feel with them. They expect us to rejoice with them when there is reason to rejoice, they expect us to share their sorrow and hardship, understand and be ready to talk with them about all their problems. Allow me to share with you one personal experience on that matter. One Sunday a man from a village, passing near my house and seeing me quietly sitting, came in sat and started talking about all his problems: his wife was ill and difficult to live with, his little daughter was abnormal and nothing could be done about it, his son was such a problem at school. It went on and on. . . and so was "my" Sunday. . . . and so I said to him: "yes, my Friend, I know you have a lot of problems, but what do you expect me to do about it? I can do nothing!" He looked at me and said "It is true you cannot do anything about it and I never expected you to. One thing only I expected from you : that you would listen and understand." And he walked away. That day I failed my friend. That day he taught me a lesson I never forgot: the importance to listen, to understand to feel with, to share our feelings.

**First and foremost Be a  
friend**



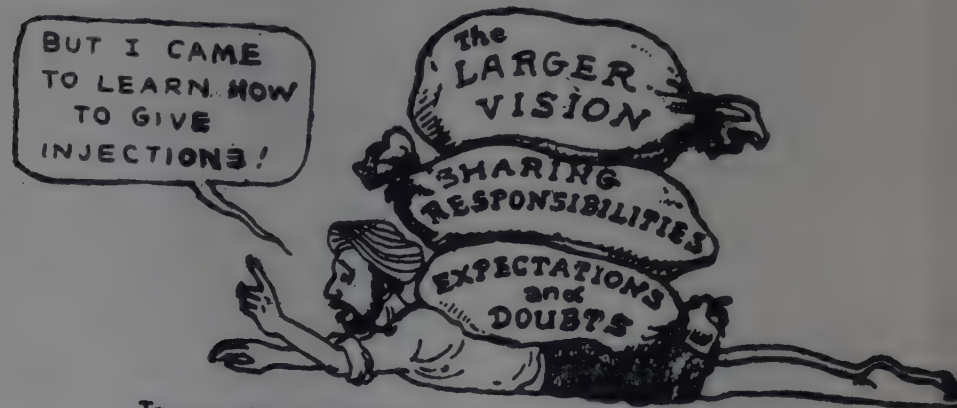
**HOW CAN I TEACH  
BUT TO A FRIEND?**

**Aristotle, "Father of Science",  
wisely said...**

It is not easy to share feelings and thus participants of training programmes must learn to do so during their training so that it becomes part of their natural behaviour. Only if we can share our feeling with a person and be sure that our feelings will be accepted and shared can we call that person "Friend".

The length of training of Community Health Workers is also important. From The Voluntary Health Association of India's experience the following point came out: a training should be long enough to allow a good understanding of the matter and to give the chance to the participants to gain enough practical experience so as to build up confidence in

themselves. We found that the most appropriate was to start with a 3 to 4 weeks residential course, after which the participants would return to work in their own programmes. Their activities would be regularly monitored by the resource persons of the training programmes during a period of 12 to 15 months. Every two or three months the participants would be gathered in one centre for a one week workshop where past activities would be evaluated and new additional knowledge would be communicated. Of course, this type of training would have to be done on a regional basis.



Try not to burden students at first with too many heavy discussions.  
Balance discussions with learning of practical skills.

Regional based training programmes have several advantages: relevant discussions on the socio-economic-cultural conditions of the area can be held and are more meaningful to the participants, regular on-the-spot visits for monitoring the activities will be easier, participants will be able to support and help each other by sharing their practical successes and failure.

In short we can say that a training programme for Community Health Workers should enable them to feel the hardship of the People, hardship caused by Community diseases, to think out what are the true causes of Community diseases, to mobilise and help a Community to work out a plan of action to remove the true roots of the Community disease, to support the community in their common effort. Seen in that light the task of a "trainer" is not easy!



## From Trainees to Trainers

Sr. Jayseeli is a member of CHAI's CHD training team.

In the past two years the Community Health Development team of CHAI conducted two long term trainings lasting for 15 months each, in Ajmer for the Mission Sisters of Ajmer and for sisters belonging to different congregations in Varanasi Diocese.

Apart from these a number of orientation seminars on community health lasting from 3 to 5 days were conducted in some of the Dioceses and short term trainings with the duration of two weeks were also conducted in a few Diocese as well as in Religious formation houses.

With regard to the impact of CHD's involvement with various Dioceses and congregations to whom orientation seminars, long and short term training programmes etc. were conducted. We have classified them as positive and negative impacts.

### The PLUS

1. There are individuals and groups who seek guidelines in their involvements by evaluating their work and planning for the future. CHD has been able to identify a few of such groups and render its assistance.
2. CHD is happy to know that there are a few Dioceses and congregations who genuinely search to improve their involvements with the people through their people oriented programme. Thus these groups are to be helped, encouraged and supported in order to fight against different which tend to nip them in their hands.
3. Many have felt that both church and government document being brought to light in order to draw strength and meaning for their involvement with the people.
4. Liturgy and faith reflections have proved effective and many participants found that Liturgy had helped them to realise the relevancy of their commitment in today's world and the need to question themselves and their type of involvement with the people.
5. The team members of CHD feel that, their involvement has widened their national perspective and urges them to go ahead to face the challenges in their activities.

6. CHD is proved to play a pioneering and prophetic role in proclaiming the message of Christ as given in Luke 4 : 18 namely "The spirit of the Lord" . . . to set free the oppressed".
7. CHD poses a challenge especially to persons engaged in medical field to be aware of the fact that the root causes of illness lie deep in social evils and the answer for this is a political one.

### **The minus**

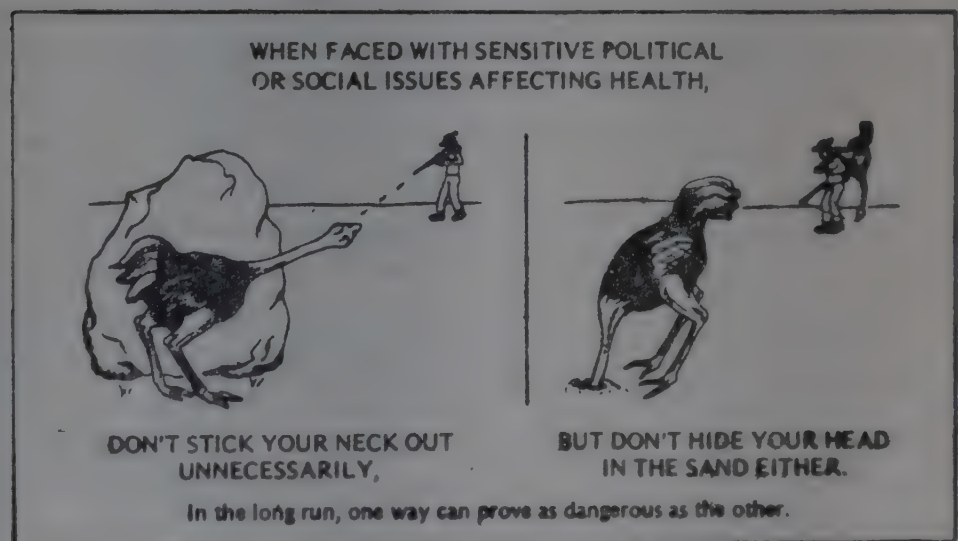
1. Though at times individuals are convinced, they are confronted with the structure in which they live and move. This creates tension within them which cannot be tackled resulting in frustration.
2. Some are discouraged since it is a long term process involving more of their time and energy.
3. Some feel frustrated at the sight of failures or show qualitative results since the others expect tangible results within a short time.
4. Some begin to question seriously the relevancy of their existence and involvement, finding no solution they feel helpless and frustrated.
5. With regard to CHD, at times it had failed to understand the important actors which are acting in operational level such as defence mechanism, power structure, internal tension within the congregation etc.

### **The balance**

1. CHD has failed to realise that different persons have their own vision and they will accept only if they find it worth accepting or else they will reject. Thus, imposing CHD's vision on persons have resulted in antagonism.
2. CHD had been illusioned at times by taking into consideration the number of seminars and trainings conducted about by the participants both within themselves and in the community in which they are involved.
3. CHD realises that there is already a movement initiated by different groups and so, by joining hands with them it will be able to neutralise the strong groups from destroying the movement.



4. CHD should be alert to recognise the new leadership emerging from the people which challenges the existing structure and so, this should be encouraged.
5. Though the documents of the church are more radical than CHD's statement, in its operational level, CHD meets with confrontation often.
6. CHD has to play a pioneering role thereby giving a relevant image to the church in the society.
7. CHD has failed to realise that in their involvement with the people the internal tension with a structure can result due to power that comes from money which is often challenged with the power that comes from the people.



Thus in order to play a pioneering role by giving a relevant image to the church in the society, CHD has to be aware of the dynamism that operates within and outside of the structure as well as the emerging of a new leadership. Faith dimension can minimise these tensions if it forms the very core of CHD's programme.

CHD is also aware of the fact that the root causes of illness lie deep in social evils and imbalances to which the real answer is a political one which should be understood as a process through which the people are made to be aware of their real needs, rights and responsibilities. By making use of the available resources, the people should be organised to carry out appropriate actions. This can be explained by an

example, if in a village many are suffering from diarrhoea due to drinking polluted water from a pond, more dispensing medicine for such will not tackle the problem of diarrhoea. Hence, the root cause namely the polluted water has to be tackled for which the people must be organised to demand from the government provision for good drinking water. This is what is meant by political action. Thus, how can the church function effectively and relevant in today's situation according to this philosophy?

Julius Nyrere says that the church must seek to ensure that men can have dignity in their lives and in their work. In order to do this he says that the church must itself become a force of social justice however they are and for whatever they are called. He also adds that the church must recognise that men can only progress and grow in dignity by working for themselves and working together for their common good.

CHD's main thrust is to make community Health a "Movement" and in this regard, it should be alert to recognise the new leadership emerging from the people which challenges the existing structure and by encouraging such groups, a new structure can be formed which can visualise not only the felt need but also the un-felt needs of the people. Moreover, CHD realises that it has to play a pioneering role there by giving a relevant image to the church in the society. These insights helped us to undertake orientation and training programmes, rendering assistance to individuals or groups who genuinely seek assistance to plan community Health programmes by evaluating their activities.

We also try to integrate community health and development in religious formation.

Through these however, CHD makes attempt to identify both individuals and groups who share the same vision, could be our partners in the field. If community health has to become a movement, it can be brought about only by the people and so, it is absolutely necessary to join hands with others of similar vision and who are interested in people's growth and development in building healthy communities. In view of this thrust and to make CHAI to function effectively as well as relevantly, it aimed at establishing CHAI units in each Diocese and thus, two seminars were held for CHAI Health Co-ordinators in both North and South zones. Two workshops were held in A.P. in view of collaboration between APSSS, APVHA and CHAI in the field of health and development.



# Programmes More Programmes

## I. Orientation Programmes

1. *Community Health Orientation Programmes* : Meant for priests, sisters and other voluntary organizations interested in community health.

Duration : 3-5 days (Residential).

2. *Orientation on Community Health and Development during formation period* : This is meant for religious personnel in the formation stage.

Duration : Varies according to different congregations and their request.

## II. Training Programmes

1. *Long term programme in Community Health Team Training* : (CHTT) Meant for teams interested/involved in people based Community health and development programme in slums and rural areas. (We concentrate more on rural areas).

Duration : 2 years (12 months intensive training (both theory and practical (and follow up in the 2nd year.

2. *One month training programme in Community Health Organisation Planning and Management* : (CHOPAM) Meant for people incharge of community health programmes, supervisors, trainers etc. at the central organization level. (Diocesan/Congregation levels, Voluntary groups).

Duration : 4 weeks (Residential).

3. *Short term training in Community Health* : Meant to update the skills of people already involved in community health programmes. A similar programme is organised also for beginners in community health, on request.

Duration : 2 weeks (Residential).

## III. Workshop

1. *Refresher Programme* : Meant for groups involved in Community Health, for sharing and consolidating experiences and clarifying concepts of Community Health, and to work out participatory planning and evaluation methodologies.

Duration : One week (Residential).

2. *Community Health Project Workshops* : Meant for voluntary organisations (on request) to clarify concepts, work out methodologies and formulate projects for possible financial assistance, from funding agencies in India and abroad.

Duration : One week (Residential).

#### **IV. Project Evaluation**

We assist voluntary organisations to evaluate their Community Health Programmes to assess, modify, alter or update the programme in line with the new trends in community health approaches.

#### **V. Documentation**

We make efforts to promote herbal and home remedies as well as other traditional and indigenous systems of medicines, since they are more accessible, affordable and acceptable to the people.

#### **VI. Promotion of Herbal and Home Remedies**

We have a documentation service, through which we make available, different handouts, resource papers, supplementary reading materials, research studies on experiments in community health, etc. to those involved in people based community health programmes.

#### **VII. Developing Linkages among Community Health Programmes**

With a view to making community health a MOVEMENT attempts are being made to develop effective linkages, among different groups involved in people based community health programmes, both in India and abroad, particularly in South East Asian countries.

For details contact :

*The Programme Director*

COMMUNITY HEALTH DEPARTMENT — CHAI  
CBCI Centre  
Goldakkhana  
New Delhi 110 001



## Bodo Khoni

### Bringing People Together

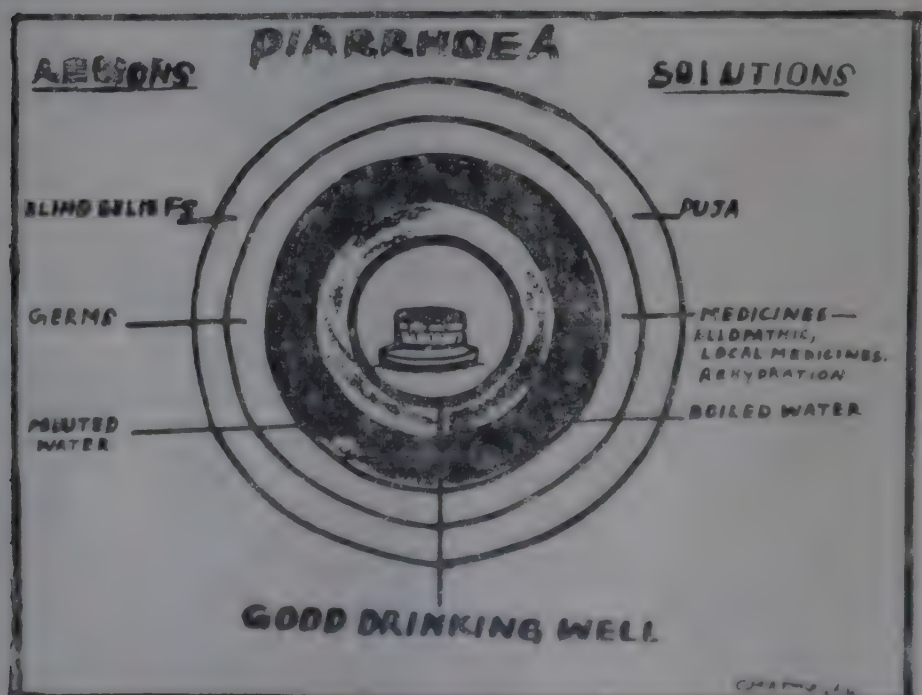
Fr Chacko Paruvananani is a member of CHAI/CHD team. He is involved in adult education programmes in Orissa.

Awareness or consciousness about a problem can be classified broadly into three levels: magical, naive and critical. The quality or nature of any action depends on the kind of consciousness one has. A magical consciousness leads one to a magical action.

For example if a person believes that Diarrhoea is caused by evil spirits he will recourse to magical actions like rituals to appease the evil spirit.

To believe that root causes of Diarrhoea are Germs/polluted water is naive. Hence Medicine and Boiled water are naive solutions. But to see the root causes of Diarrhoea as lack of good drinking water, lack of food, unjust distribution of land, unjust wages needs a critical thinking and the actions which follow will be critical or radical, means tackling the root causes of the problem.

The role of health animator is to enable the people to move from a magical understanding of their problems to a critical one so that they can strike at the root causes of their illness.



We belong to a small village named Bodo Khoni, in Mohana Block of Ganjam District in Orissa.

We found one of the root causes of Diarrhoea in our village was lack of good drinking water. Therefore we came together and discussed it in depth. We realised that it was our responsibility to maintain our health and the health of our children.







But people in our neighbouring village took another decision to solve their water-problem. They marched together to the block development office to demand for a well because they realised that good drinking water was their right as citizens of India and that it was denied to them unjustly. They too got a new well.

This is the common well dug collectively by us. We are very proud of our achievement. This well is a symbol of our unity and mutual concern. Since it is our well we keep it clean. What we did can be done by any village in India.

The role of the health animator is to enable the people to exercise collectively their responsibility to maintain their health and to demand health as their right.

I am from the same village Bodo Khoni, in Mohana Block, Ganjam District of Orissa.

The villagers elected me to undergo some training in community health and development. Though I knew very little of reading and writing I learned a lot and I began my work.

I realised that most of us, including me, were spending money and time unnecessarily to go to doctor for any ache while most of the cases could have been treated by any one of us and many cases were self curing.

The money thus wasted could have been used to buy food. Health is in our hands and we need not buy it from specialists for the price they arbitrarily fix. We are already poor why should we allow ourselves to become poorer through medical exploitation?

Though I started to treat some common diseases in the village I soon realised that they could not be eradicated unless the root causes of these diseases are tackled and this could be done only through the collective effort of the villagers.



So I thought of bringing all the people together to reflect on their village problems. People were very enthusiastic to discuss their problems related to health and development.

The non-formal get together became a regular feature. Sometimes people from CHAI and other organisations give us some guidelines.

As a result of these non formal get-together and discussion we felt the need for more organised bodies in the village to take concrete decisions and action-programmes.

Thus we formed ourselves into two village organisations: Mahila Sangho (Women's organisation) and Gramya Sangho (Men's organisation).

Here are our mahila Sangho members. We discuss mainly problems relating to women and the education and health of the children. Now we realise that health is not mere absence of illness. It means ability to express our opinions and to take effective decisions concerning health, development, cultural





life and also to elect our own representatives for the panchayath. It means physical, mental and spiritual wellbeing.

#### The Gramya Sangho Members.

Both the Mahila Sangho and Gramya Sangho have elected office bearers like President, Vice-president, Secretary and treasurer and have at least once a month a meeting. Both these sanghos meet together whenever a common action is to be undertaken.

Now we are confident to tackle the problems of our village one by one in a very organised way. For example:

#### *Our village shop*

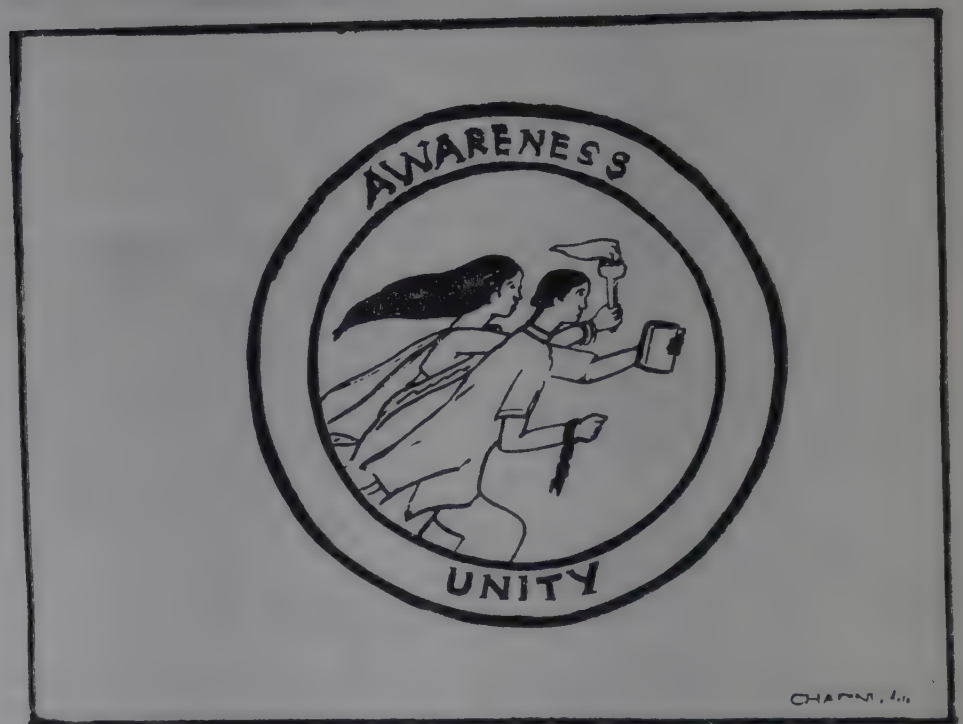
We were depending on the merchants who came from out side for our essential commodities like rice, salt, kerosene etc, and they made enormous profit because they fixed the price arbitrarily and we had to pay.

So we discussed this matter in our regular meetings and decided to put an end to this exploitation which really affect our health. Unless we get good food items regularly at a price affordable we will have always the diseases arising out of malnutrition. But to initiate a shop we needed money. So we started a saving-scheme. Now we have a shop and the merchants do not come to exploit us. This same shop is used as a grain bank so that we can have always some food grain even in lean seasons.

In order to improve our purchasing power and the unity of the village community we decided to avail the government resources. Thus we began to have a community goat-rearing programme subsidised by the Integrated Rural Development Programme (IRDP) of the government. The Goats are looked after by the Families by turn, and the profit is used to initiate similar programmes.

In our regular evening meetings we have initiated a functional literacy programme for those who cannot read and write. Now most of us can read and write what ever we really need in our day to day life. We are proud of it.

We have also started a non-formal school for our children. Our children too learn about the village problems and they too have begun to contribute their share to build a healthy community.



We are poor but we have our own dignity and our own cultural talents. We want to develop all our talents. Till now we with our culture were kept suppressed by the rich and the powerful. Now we are rising up from a culture of silence and oppression to a culture of enlightenment and self-dignity.

The role of the village level animator is to enable the unorganised and the marginalised to get organised so that they can be craftsmen of their health and development and creators of their own culture and history.



# Management as Redistribution of Power

Dr. Ashok Dayalchand is Coordinator of Comprehensive Health Programme, Pachod, Aurangabad District

In India the concept of Primary Health Care (PHC) was espoused as far back as in 1940, by the Planning Committee of the Indian National Congress, and later by the Bhore Committee in 1946.

During the past decade or so, several experimental PHC Projects were initiated by Voluntary Organisations in India. These Projects made important contributions to International thinking, on key issues such as role of village health workers, and community participation.<sup>1</sup>

On October 22, 1977 the Community Health Workers Scheme was launched by the Government in an effort to establish a community-based health programme in India.

The programme was beset with several problems right from the start. Its credibility suffered because of the controversial personality of the then Health Minister, Shri Raj Narain, who first announced the Scheme.

The medical fraternity reacted against the programme, reflected in the editorial of the July 1978 issue of the I.M.A. news, the Journal of the Indian Medical Association which dismissed the Scheme as "a political eye-wash and enormous waste of money".

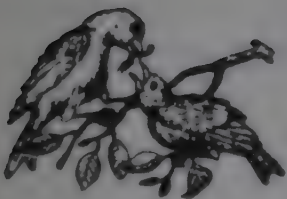
Dissatisfaction of CHWs with their modest honorarium led to demonstrations and demand for better remuneration.

Despite these initial problems, evaluations of the Scheme suggest that it directly benefitted women, children and weaker sections of the community by providing greater access to curative care from CHWs and through referrals to higher level of health care.<sup>2,3</sup>

To some extent the Scheme made village communities more aware of preventive measures and educated them to demand better government health services as a right.

CHWs have proved to be a useful link between the health authorities and the community.<sup>4</sup>

However, the Scheme has not come up to expectations in operationalising the concept of PHC, as defined by the Alma Ata conference in 1978, which acknowledges its dependence on many factors related to national, community and



**\*FEEDBACK:** helpful ideas and suggestions sent back to planners or instructors by health workers.

individual, social and economic development. The concept is dependent on mobilising popular support and community participation in decision-making. Health care is just a part of such a development process.

The ambiguity related to these concepts is partly responsible for the shortfall in the success of this Scheme. Since its initiation, however, further insight and experience has been gained in the practical application of these concepts. It is possible now to separate fact from the rhetoric, accumulated over the years, on concepts like mobilising community support, community participation and decision-making by the community. To translate these general definitions into operational terms, it is necessary to determine precisely, the process of management in which the community or its representatives can participate.

Most of the available literature on Management of Health Services tends to distinguish between Planning, Evaluation and Management as a result of the emphasis on "specialisation". While it may be possible theoretically to separate these conceptually, the concept of PHC can be implemented only if the distinctions between Planning, Management and Evaluation are eliminated and merged into a single process.

This paper endeavours to provide an operational framework of management which incorporates planning and evaluation. It argues, illustrating with case studies, that only when these processes are used as management tools, can the community participate in decision-making in health services.

With the earlier gains made after initiating a community-based health programme in the country, it is possible to bring about rapid social change by introducing participatory management.

#### **(A) Ground Policy**

Basic considerations for arriving at ground policy are social need and demand, and organisational capacity and constraints.

#### **(b) Planning Process**

Consideration has to be given to : assessment of need, subgroups of the community with the greatest need, and forecasting demand. In case of a perceived need that has not found expression, promotional campaigns may have to be planned for creating demand. Communication channels to

**Participatory Management, Social Research and Evaluation**

*Operational Frame-work  
Participatory Management*



be used for such promotion will have to be decided. Henceforth the process of need assessment shall be referred to as "social research". Planning would include decisions on who will conduct such research, how is this information collected, to whom is it reported, and what is the feed-back mechanism? Finally, the most important question at the planning stage would be, what is the purpose of such research.

Assessment of need implies the existence of a problem. Alternative solutions emerging from social research need to be examined. Solution criteria and solution constraints need to be identified. Decision has to be taken regarding the most acceptable alternative.

**(c) Organising Process**

This process involves definition of tasks, definition of jobs, and division of work. Decisions regarding extent of delegation vis-a-vis centralisation will have to be taken. An important consideration in this respect is to ensure uniformity and consistency. One would also have to consider if the process involved can be sustained over a long period by the organisational structure being planned.

**(d) Executing Process**

In social welfare programme there is need to give consideration not merely to the motivation of workers but also to the community which is expected to avail of these services. At which levels would monetary incentives be more effective as compared to job satisfaction and self-actualisation. Lines of communication and control have to be established and their levels identified. Leadership requirements at different levels need to be identified, and formal or non-formal leadership needs to be inculcated.

**(e) Controlling Process**

This requires reporting and monitoring systems, parameters of evaluation, a feed-back system, and re-examination of objectives and goals after evaluation. Other considerations are cost-effectiveness and employee-satisfaction.

**(f) Decision-making process**

This is an all pervasive process related to all the other processes of management. Decisions have to be taken at every level and every stage of project planning, implementation and evaluation.

Having identified the processes of management, one needs to examine their implications for the health delivery system. In India, government and voluntary organisations are involved in the community health workers and dai program.

mes. Both these programmes were an extension and decentralisation of hospital based health delivery systems which had traditional organisational structures and hierarchical management systems. This conventional management perspective has not been successful in providing health care especially to those who have the greatest need. This led health managers in search of alternative styles in management of health services.

Participatory management is not a new concept in industry and business. In Drucker's opinion, delegation and decentralisation are the corner-stones of good management.

Whereas in industry participatory management has conclusively shown to increase and streamline production, the applicability of this concept to social welfare programmes is not as simplistic. Apart from leadership style and delegation of responsibility, the interface of the organisational structure with the community has to be taken into consideration.

Participatory management in social welfare schemes essentially means making the community and its representatives participate in taking decisions related to all the processes of management.

## **B. Participatory Social Research**

An important, yet most neglected process of management is "planning". The process of inquiry, imperative for planning a health programme is referred to as "social research" in this paper. In context with the delivery of health services, social research is of prime importance because in the social setting it involves identification of the weakest sections of the community to ensure utilisation of services especially by those with greatest need.

### *Classical Social Research.*

One of the most visible characteristics of traditional research is the remarkably skewed power distribution between the researchers and the so called 'subject'. The researcher has complete power to decide upon the focus, methods and outcomes of his study.<sup>5</sup>

This approach in social settings has placed primacy on developing research designs that attempt to maintain the separation between the researcher and individuals in the social system under study. Such an emphasis will seem misdirected if we examine the three distinctive characteristics of inquiry in social settings.



## *Participatory Social Research*

Participatory research maintains that the actors in the situation are not merely objects of someone else's study, but are actively influencing the process of knowledge-generation and elaboration.<sup>7</sup>

Whereas traditional research is more academic, participatory social research is a management tool where reflection and self-assessment are critical to the process especially if it insists on equitable distribution of resources.

The insistence that the oppressed engage in reflection on their concrete situation is not a call to armchair revolution. On the contrary, reflection — true reflection — leads to action. On the other hand, when the situation calls for action, that action will constitute an authentic praxis only if its consequences become the object of critical reflection.<sup>8</sup>

Participatory social research implies a collective inquiry by the manager and the community (objects of research), a re-distribution of the power to take decisions in the establishment and management of a health delivery system which is for their benefit.

Why is participation of the community sought in the conduction of social research? It has been demonstrated that where the community was involved in assessing its needs and planning of its health services, it was followed by increased awareness and a demand for health services. The community could be mobilised into action for determining solutions to their own problems and taking decisions in the management process.<sup>9</sup>

The relevance of traditional social research for academic purpose and macro level planning cannot be disputed. However, for purposes of management, participatory social research despite its lack of objectivity, is necessary. The purpose of participation here is to allow the decision-making process to be decentralised so that the community is involved in planning implementation and evaluation at the micro level, in other words, for mobilising community action.

Three possible actions can be expected from the community through its participation in social research and management.

### **(a) Self-help:**

Health education, leading to health awareness, it is expected would result in community initiating in meeting its own health demands. The concept was popularised as "Health by the People", which taken to the extreme implies an ultimate redundancy of Health Providers.

**(b) Demand health services from Providers as a birth right**

WHO has defined health as a right of the people to be provided by the State to all without discrimination. To ensure accessibility and equitable distribution, the second option is to make the community politically aware of their rights so that they make demands on the health system till their needs are met. We will refer to this process as "political awareness." The concept puts the onus entirely on the Provider.

**(c) Participatory Management – Both Community's and Provider's initiative**

The third possible community action that can be expected is that the community participates with the Providers of health care in all the processes of management of the health delivery system. This concept we will refer to as "participatory management".

**C. Participatory Evaluation**

According to dictionary, to evaluate is "to examine and judge the work, quality, significance, amount, degree of condition".

Who evaluates a programme, depends entirely on the purpose and objectives of the evaluation. Traditionally, evaluation is a special, deliberate exercise commissioned by the donors, sponsors, or project holders. It is viewed as a specialisation, to be conducted by one or more expert individuals.

Based on such terminal evaluations policy decisions are taken to continue the programme, continue support, change direction, emphasis, change personal or material resources, etc., depending on the results.

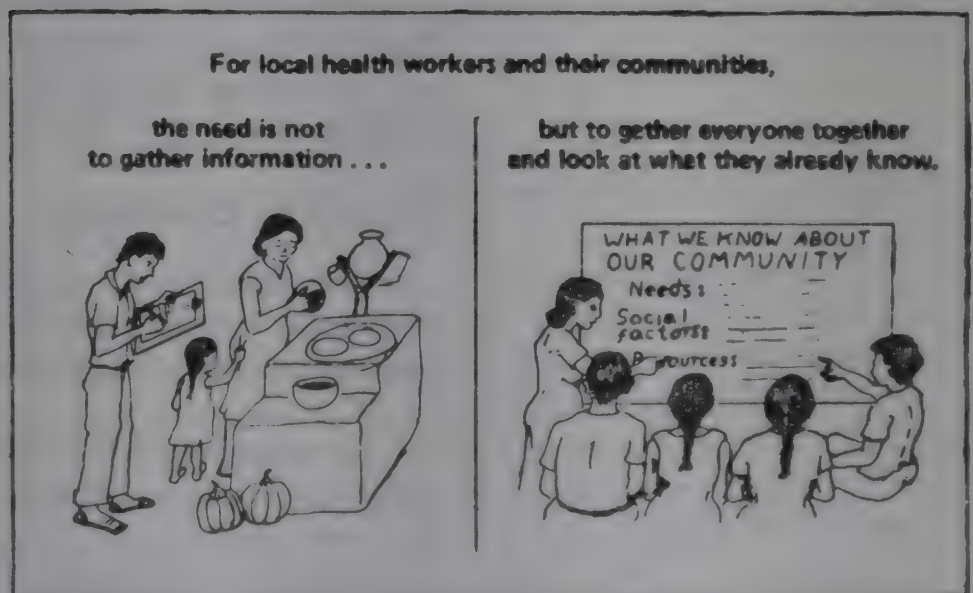
Almost all definitions of evaluation have decision-making the pivotal point. It is the process of ascertaining the decision areas of concern, selecting appropriate information, and collecting and analysing information in order to summary data useful to decision-makers in selecting among alternatives. It is meant to set up indicator values to targets and the subsequent reporting of the indicator values along with their deviations from the targets, wherever applicable, to the relevant decision making levels to enable them to take necessary action. It is a method of detecting strengths and weaknesses of programmes and of recommending measures for improvement to decision-makers.<sup>10</sup>



In summary, participatory management implies a redistribution of the power to take decisions. The process initiated through participatory social research enables the community in the assessment of its own need and in deciding its priorities. Only then can the community be involved in decisionmaking during the subsequent processes of planning, organising, execution and evaluation.

Participatory management, it has been demonstrated, can increase health awareness, effect community reflection on the responsiveness and effectiveness of the health system, increase demand for health services and contribute to social change.

This does not imply that the role of the provider can become redundant with increasing levels of community participation in decision-making. As long as there is need for health providers, managers and administrators will have to contend with the vertical organisational structures of the health system and the need for horizontal integration with the community and its representatives.



Training of health managers and administrators in participatory management cannot be overemphasised.

## 1. Training :

The manager will have to choose between the structural and human relations perspective. A leader with human relations perspective will influence decision-making at all levels, and needs to understand that in community health a structural perspective will not be successful. The leader has to see his role as people-oriented rather than taskoriented.

## 2. Management Style

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COMMUNITY HEALTH CELL 51  
326, V Main, I Block  
Koramangla  
Bangalore-560034  
India

*Implications of Participatory  
Management, Social Research  
and Evaluation*

## CASE STUDIES

When viewed from a management perspective participatory evaluation can be defined as a process of self-realisation where an organisation working with the community studies the strength and weaknesses of its programme through the participation of the community and all level of workers.<sup>11</sup>

Similarly, participation of the community and various levels of workers cannot be expected in a terminal isolated process of evaluation unless participation is woven into the fabric of the programme in such a manner that the community and the workers participate in decision making, assessment and steering from the very beginning.<sup>12</sup>

Perhaps the greatest weakness of our health system both in the government and voluntary sector is the near absence of in-built evaluatory systems that can be considered a part of the management process. To compensate for this lack of concurrent evaluatory processes the dependence shifts to terminal evaluation by "outside" expert evaluators. However, evaluations by individuals are circumscribed by limitations in perception.

Participatory evaluation provides an alternative which if perceived as a process of management can be introduced and developed within the frame-work of an organisational infrastructure right from its inception.

### **Origins of Concepts**

The concept of participatory research and evaluation originated through groups engaged in the process of re-awakening the weaker sections of society.

As examples of such efforts one may mention the organisation of landless labourers in Dhulia district of Maharashtra that has used similar methodology in identifying the records of people whose land was illegally alienated from them. Another well-known case is the Chipko movement in Uttar Pradesh, where, as a result of people's reflection on the causes of the 1970 floods, deforestation caused by some industrialists, the forest department's refusal to let the local poor use the Ash trees for their needs and the permission they granted to commercial contractors and industrialists the people organised themselves into a resistance group. A community forestry scheme based on the right of the local people to the forest produce and the maintenance of its environment was born out of it.



These experiences led to the belief that technocrats and external researchers will soon become redundant.

This concept which originated and was successfully demonstrated in essentially socio-economic issues was grafted in its original form to health delivery systems. The applicability of this concept to the health delivery system needs to be re-examined.

### *The Dilemma of Health Managers*

Eighty per cent of the ill-health is due to poverty and poor living conditions amongst the weaker section of the society. Ensuring this section of the society with optimum health services involves several factors such as accessibility, equity, utilisation which, in turn, is determined by changing social norms and concepts of ill-health.

The mere provision of health facilities does not ensure accessibility, equitable distribution nor utilisation by the community. This becomes evident on reviewing the situation in Punjab where for several years the State has increased P.H.C. facilities to one doctor and two multipurpose workers for every 5,000 population. But it has not had any appreciable impact on the health status of the community, especially its weakest section.

Experience shows that health education by itself, has not led to health awareness and increased community initiative towards "self-help".

Political awareness leading to increasing demands on the system is possible only after health awareness is created. Effective health education is not possible without meeting the existing health needs of the community. Health managers are, therefore, faced with the dilemma where they have to work with, or establish an organisational infrastructure to deliver health services. Here they have to deal with traditional hierarchical management systems. On the other hand, they soon realise that health organisations with such traditional organisation structures are ineffective in bringing about change in the health awareness of a community.

The lack lustre performance of the C.H.W. Scheme is not due to ideological fallacy, but because of faulty implementation. Mere representation of the community in the health system through its health worker can neither mobilise the community into action nor make the health system more responsive. On the other hand, this community-based health system has proved an effective tool in the hands of health managers to establish participatory social research and management processes.

Having redefined the processes of management in congruence with a participatory perspective, it is essential that the tasks involved in each process be clearly stated. Involvement of different levels of workers and the community and its representatives in the tasks pertaining to each management process can then be clearly worked out. A matrix organisation will emerge with both vertical and horizontal integration. This would serve the management needs of both health organisation and its interface with the community, both of which the health manager is expected to contend with.

## Community

Participatory management in the health services implies that the community and its representatives are involved in the decision-making process as it relates to all the management functions. For case studies refer "Evaluation in Primary Health Care: A case study from India" by Dyal Chand A. et. al. in "Practising Health For All" edited by David Morley, et. al., pp 87-100 (1983).

The community can be invested with this power and its interest sustained only if they have a stake in the formal system. Since the bulk of ill-health is restricted to the weaker sections of the society, the services and consequently the participatory involvement should also focus on this subsection of the community. With the introduction of the C.H.W. and Dai schemes at the national level, the tools for enabling participatory management and ensuring equity in health services have already been provided to the health managers. The following are some steps that would ensure equitable access of services and participatory involvement of the weaker sections of the community.

1. Selection of C.H.Ws and Dais from the weakest section of the community so that they have a representation in the management process.
2. Provision of health services to sub-groups of the population instead of an individualised house-to-house delivery system. This is possible with the establishment of health posts in each village where sub-groups of the community with a common interest will come to receive a particular service as a group. For example, pregnant women receiving ante-



natal care, parents of children under five bringing them for child health care. Without discriminating on basis of socio-economic status a venue is created for people of different interest groups to meet and interact when they come to utilise a health service.

Interaction does not automatically occur; it has to be orchestrated. This group interaction should lead to a rapid diffusion of knowledge, formation of peer groups capable of taking decisions and establishing health norms in their society. A two-way feed back system for participatory management evolves through the community representatives.<sup>13</sup>

3. The community must reimburse its health worker. Only then will it feel that it has a stake invested in the health system and that the system is accountable to it for its health needs. This will also ensure the direct accountability of the community health worker to her own people.
4. Once peer groups are established, psycho-social methods of health education need to be used. Question-answer, problem solving techniques which generate group interaction have led to rapid diffusion of knowledge. It must be kept in mind that health awareness is not restricted to individuals. It is essentially a change in community norms and concepts.
5. Finally consideration should be given to the extent of participation of the community in the decision-making process. Can the community representatives be integrated into the system? Community representatives as integral part of the management system would require their representation and active involvement at the policy, executive and controlling levels.

Alternatively, the community representatives could interact primarily with the community facilitating decision-making for all management processes including ground policy, and this could be "articulated" with the management functions of the health system. Combined with the National Policy of decentralised health services, participatory management could bring about rapid changes in health awareness and social dynamics in rural areas in the country.

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## New kind of Rehabilitation Workers

The text of the introductory remarks by David Morley, Professor of Tropical Child Health, University of London, on the occasion of the opening of the Community Based Rehabilitation Course.

You and I have had opportunities to visit physiotherapy centres, limb-fitting workshops, schools for the deaf or blind and many other similar institutions in developing countries. Run by dedicated and hard working individuals, they do a magnificent job, but on limited resources. Should we have the opportunity to re-visit them in 5 or 10 years' time, we will not find them very different from what they are today; nor shall we find very many more of them.

These institutions care for less than one per cent of those with disability. As the health budget in most developing countries per head of population, is only 2% of a comparable health budget in a European country, any increase in the number of these institutions is clearly impossible. As long as we put all our resources into these "European style" institutions, we are stuck in a rehabilitation "cul-de-sac", that we need to get out of.

The World Health Organisation and a number of other international and national organisations have developed the concept of the Community Based Rehabilitation Worker. He or she will work in a rural situation or in a shanty town of 20-50,000 people. The workers will identify the 2-300 disabled individuals within their area, and will bring, through the community and the families of the disabled children, simple but effective approaches and technologies.

Let me take one simple example. We can expect the population of an area such as I have described to have at least 50 children and young adults severely disabled as a result of poliomyelitis. Aina, a 2 year old child has had weakness of her legs for a year. Construction of simple bamboo parallel bars by her father permits Aina to exercise at home her weak legs, helped by her brothers and sisters, no doubt, on the CHILD-to-child principle.

Aina has progressed and she now uses a locally made walking frame. Her sphere of contacts will no longer be the hut in which she was born, but now her whole village. Aina as a disabled child was what is known as a 'high risk' child.

## Many Ways of Tribal Participation

Fr. Van Besouw is Associated with RAHA.

The RAHA (Raigarh—Ambikapur Health Association) is the informal and as yet unregistered grouping of 3 Base-Hospitals and 47 small rural health centres, under the leadership of an executive secretary and two or three full-time health coordinators.

Although started in 1969, RAHA became active in Community Health only from 1974 onwards.

*Basic Data of the Project area :* Raigarh and Surguja Districts Madhya Pradesh is one of the largest Indian States with a population of 52 million. From among the 45 districts, Raigarh and Surguja on the Eastern side have an area of 35,437 km<sup>2</sup> with a population of about 2.5 million. The density varies between 70 to 100p/km<sup>2</sup>. The region consists of elevated tablelands dotted with numerous rocky hills and jungle tracts. The highest plateau (950m) descends to the next lower one by sudden steep slopes till it reaches the lowest at about 300 m above sea-level. The many small and shallow streams which are nearly dry during most of the year, become roaring cascades in the rainy season. Apart from National Highway 23, and a road to the coalmines of Surguja, there are few all-weather roads.

### The People

The tribals form 52% of the total population in the project area with much higher concentrations in the remote and isolated villages. In spite of centuries of oppression and exploitation, the "adivasis" or original dwellers, are peace-loving and happy-go-lucky people. Dancing and singing, accompanied by drums and flutes, are the main amusements. Their mud-houses are roofed with locally baked tiles. Inside you'll find mats, utensils, earthenware, axes, weapons, drums and clothes. The stock of rice is ingeniously tied up in a barrel of straw rope. Women hold an honourable place and go freely about the country side. In the fields and in the jungle they work in happy companionship with the men. Of outstanding courage in the face of wild animals, the tribals feel actually fearful towards strangers. Their economy is not really focused on "increasing production", but rather on fulfilling the needs of



immediate consumption. Apart from preserving seeds for the next sowing season, they freely spend all they have. Because the tribal rarely has enough to eat, this propensity for consuming what he has, is somewhat understandable. His willingness to share, on the other hand, is remarkable. Motives of profit and competition are remote. He has a strong attachment to the land, and his social standing, his sense of dignity and feeling of security depend on the amount he possesses.

*Another mental attitude of the tribals need to be mentioned : the need to move together.* This basic survival technique of former times can easily lead to a 'heard-mentality' and to something that is called 'Hisinga' or jealousy. It cuts down individuals, who are going ahead too far, like the biggest trees in a plantation that overshadows the rest. However it can also be built up into a real sense of solidarity when an immediate benefit for the individual is sacrificed for the future greater benefit of the group. Nearly every village has a BAID. These are really herbalists, who know the curative properties of roots, leaves, etc. Most of them are sincerely interested in the welfare of the sick, but they do not easily reveal their knowledge since, according to them this could take away the power of their remedies.

### **The Village Health Promoters Training Programme**

We shall not elaborate on the general ideas of "Community Health", but only clarify how RAHA applied these in practice.

In the general meeting of September 1974, it was decided to try out a decentralised educational programme to train village Health Promoters with the help of a Mobile team. The first camp was held in January 1975.

Volunteers from 5 different religious institutions formed a mobile team. Some of them were nurses and some social workers. The village leaders were approached. Villages are relatively small (25 to 100 households) and each health centre caters to 50-100 villages. With the backing of the village leaders and the religious leaders/parish priests, the need for effective and preventive health care was explained. The people began to realise that they would no longer be forced to sell their cattle or fields to save the life of a sick relative. The people were then invited to select from among themselves a man and a woman who were settled in the village, who were accepted as leaders and who, through their proven devotedness and ability, gave reasonable hope that they would effec-

tively and generously help the community. Although men are the traditional healers in tribal society, also the women were invited since they do most of the nursing.

Every year from November till June, the mobile team was conducting short, intensive health-camps in the rural health centres for the group of candidates thus proposed by the villages. Several months later, the persevering ones were called for a second health camp, after which they received an elementary medicine kit, free of cost. The traditional midwives (dais) were also trained in separate camps specially designed for them.

The training camps in fact are chiefly aiming at starting the movement, at starting the pendulum swinging. The success of the Mobile Team and the wholehearted response of the people were mainly due to the personalities of the team members rather than to their medical qualifications. The momentum of enthusiasm, cooperation and team-spirit generated at the camps, carries the VHPs far, but it would eventually die out, if there were no coiled-up spring ready to give new energy to keep the pendulum swinging. This is the role of the nurse at the health centre. She can multiply her services to the people by the number of VHP's she can animate and guide.

The VHP's do not get any remuneration from RAHA, except a meal on the monthly meeting day since many have to walk a great distance. From the beginning RAHA has been careful *not to develop an employee mentality* among them. Their work is considered as a challenge to their generosity. However, we favour the giving of an annual remuneration by the village to the VHP's in accordance with tribal custom.

The *monthly meeting* is of crucial importance. All the VHP's then exchange their experiences, their records are checked, the medicine kits are restocked, new initiatives are discussed and further improvements are planned. It is a great encouragement to do things together, to feel you are working in a team that understands and appreciates your efforts. These meetings are the ordinary and steady communication channel upwards and downwards.

### **The School Health Programme**

Started in 1980, after a workshop by VHAI, it met with only limited success. Volunteer school health guides were chosen from among the staff, physical check-ups were organised and a dentist visited the main centres. But only after a



full-time coordinator took up the work in 1983, did the programme get off the ground and has now 109 teachers who work as part-time volunteers in their schools; the majority being in the remote village primary schools. Twice a year, a refresher course is organised for them.

### **The TB Control Programme**

is on the launching pad. In tune with the policy of the Ministry of Health, the stress will be on case-detection by smear-microscopy and ambulatory treatment by standardized regimen. About 15 selected RAHA Health Centres will be equipped and staffed for smear-microscopy and will handle the smears of all 'suspects' coming from neighbouring health centres. Treatment, fully supervised for the initial two months, will take place at all health centres. Our staff will be trained by the National TB Institute, Bangalore.

### **The Medical Insurance Scheme**

People must be taught to prevent disease, but they should also be protected against the economically crippling effects when unavoidable sickness or accident strikes. In these cases, medical care and hospitalisation are beyond the paying capacity of most of our people and certainly of the poorer.

Therefore, in order :

- to facilitate essential medical care to the rural areas on a cooperative basis so that the crushing burden on a few, could be carried lightly by many;
- to act as an incentive to increase participation by the people in the total health programme,
- to enable our base hospitals to fulfil their priority-objective more effectively, namely medical services for all including the poorest,
- RAHA has gradually built up an original system of insurance.

It rests on *three pillars* :

1. *A great number of people must take part*
2. *There must be a great stress on prevention.* Every group that takes part, must be actively engaged in preventive and protective measures under the guidance of the nurse and the dedicated service of a Village Health Promoter.

3. *A spirit of solidarity must be the main motive.* This is as essential as the two previous ones. If everybody tries to get back his money's worth, irrespective of his medical needs, the whole scheme is bound to fail. The motto should rather be : 'I pay for my brother, and my brother pays for me'.

More than 5 years of training Village Health Promoters preceded the start of our -M.I.S. (Medical Insurance Scheme). Even then we made the mistake of focussing on insurance for hospitalisation in the beginning. There was very little or no response, because nobody wanted to be hospitalised. A proposal for "local treatment" — insurance got a better response. At first people did not have the slightest idea what "insurance" meant and how they could benefit. After four years of operation, they have experienced the enormous advantages. The yearly membership fee was gradually raised. (We started with Rs. 1/- per person per year, then Rs. 2.50 then Rs. 4/-) and membership grew from 2000 in 1980 to 45.000 in 1984.

**How does it function at present ?**

We work in a two-tier system. The local insurance fund at health centre level is called the "Samaritan Fund" and is locally managed. The "Central Fund" which takes care of the hospital-referrals is centrally managed, although it is fed by yearly contributions from the different Samaritan Funds.

*The Samaritan Fund has as purpose :*

- to give free treatment to the members (according to it's capacity)
- to finance all other preventive and protective measures, as needed,
- to foster early treatment, independent of economic conditions, which is the secret to keep cost of treatment low. A person who does not have to pay at the time of treatment, will be inclined to come early.

*Eligibility:* those who belong to the economically weaker section, irrespective of religion, but who can be trusted to join in a spirit of solidarity, and are ready to take part in the preventive measures. The services of an active VHP is therefore essential.



*Collection of the Fund* : is chiefly through membership fees, which have to be paid, once a year and two months in advance.

Repeatedly changing the fee was disturbing, and now all have agreed to pay yearly "the value of two kilos of rice per person". The collection can be done in cash or in kind. This linking to a common market commodity avoids the need for frequent changes, allows for minor local variations, fosters early collection (during harvest time; Dec/Jan), and will show a yearly increase in real value to match the increasing cost of treatment. (N.B. The whole family should join. Unborn children are insured with the mother, and concessions can be given to nuclear families with more than six persons).

*Management of the Fund* : the money collected is kept at the local health centre, and the members are regularly informed through the VHP's of expenses incurred/income received. With temporary assistance from donor agencies, RAHA has so far been able to double every rupee collected by fees. This was necessary since fees were very low, and the number of members still insufficient to be fully self-reliant.

If the Samaritan Fund is insufficient to last a whole year, restrictions can be agreed upon (excluding tonics, and vitamins, or part/full payment for injections).

The Samaritan Fund is not just an insurance scheme. It acts as a catalyser for community participation. It is the change over from the old system of health care where everyone pays for himself and which was consequently limited to those who could pay, to a self-reliant community health care system which includes the poor because each one pays for the other, and the others pay for him. Through the Samaritan Fund (sp. through prevention and early detection/treatment) we see the sick diminish in number and the poor can equally benefit because all share the burden. It is an implicit invitation towards concern for one another and gives our health institutions the opportunity to serve those for whom they were originally started.

#### *The Central Fund and the Hospital Referral Scheme.*

This forms the second tier. Part of the money collected for the Samaritan Fund (Rs. 2/- per persons) is paid into this Central Fund, from which the hospital bills of member can be paid. (patients pay only a nominal Rs. 100/- per case).

### Conditions for referral :

1. Only those who have paid their contribution to the Samaritan Fund. two months earlier, can benefit from the scheme.
2. There must be an active Village Health Promoter in the village who regularly attends the monthly follow-up meetings. He/she fills in a form, showing the care that has been taken to prevent the disease, if applicable.
3. The health centre has to have a sufficiently qualified and experienced nurse who effectively takes care of both preventive and curative needs.

### Method of Referral :

Normally a sick person first reports to the VHP who, when the need arises, informs the nurse or sends the patient to the health centre. Depending on the case, the nurse has then to decide whether the patient needs to be transferred to the doctor/hospital. The patient comes to the OPD of the hospital, with a RAHA referral card giving essential data. The patient comes with Rs. 100/- in hand. (in case the patient is too poor to find Rs. 100/-, the nurse advances part of it.)

If treated in OPD only, the patient pays up to Rs. 100/- only. If admitted by the doctor, the patient pays the full Rs. 100/-, as his share of the bill. RAHA pays the rest up to Rs. 1000/-. No individual acquires the right to be admitted. Only the doctor decides when and how long the patient shall be admitted. The patient has to arrange for his own food, and be accompanied by a companion who sees to this and other needs.

### Limitations

- no case older than one month, should be given a RAHA referral card.
- no case, resulting from a criminal action, will be considered.
- T.B. patients are covered by another programme.

### Can this Medical Insurance Scheme become self-supporting?

- at the health centre level :  
the real cost of treatment can be kept low  
If people take an active part in prevention



If they report early, or are detected early

If, after correct diagnosis, treatment is started without delay.

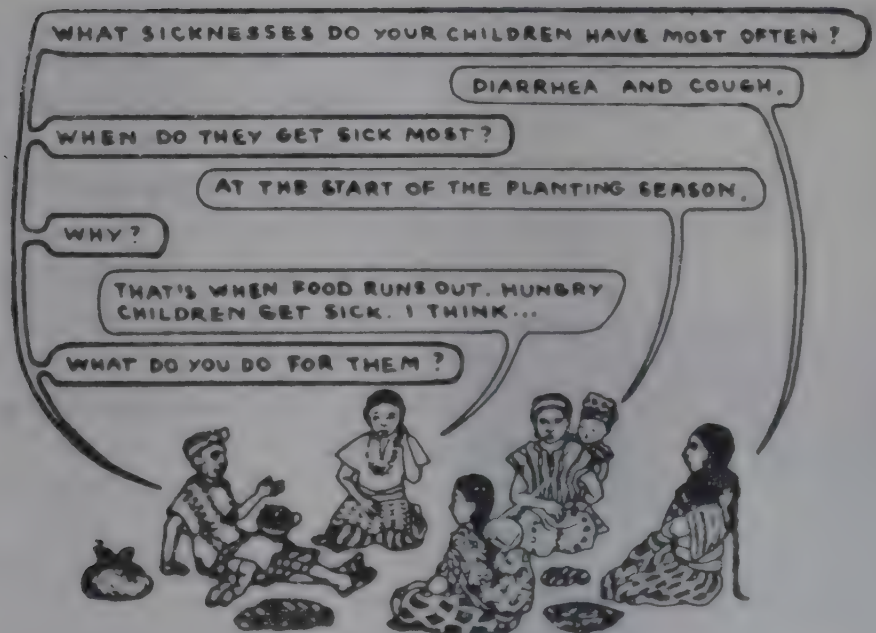
If nurses and people are gradually educated towards a low-cost and rational drug-therapy.

If all protective measures (immunizations, etc) are used.

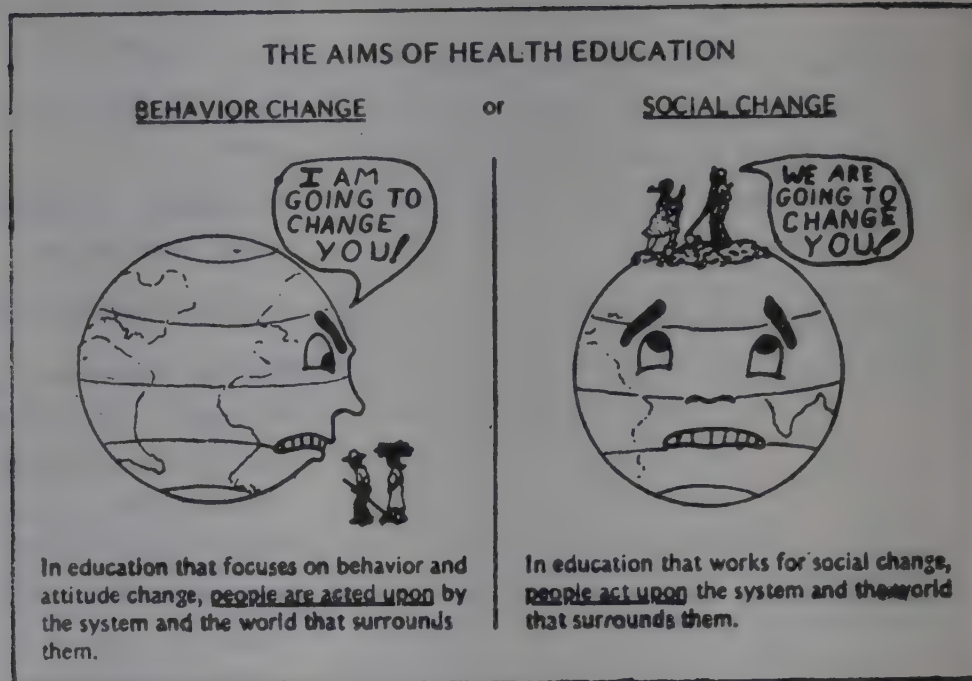
If herbal remedies/inexpensive home-remedies are used judiciously.

— at the hospital level:

for the first three years, we saw a big increase in the number of patients referred: 300-500-700, in the fourth year it levelled off at 600, perhaps drop further to 500, as prevention and immunization is practised more widely. The average cost per patient was less than Rs. 400/-. At the present rate of contribution (Rs. 2/- per person), we would need about 100,000 member to cover all the hospital bills. This is not impossible to achieve with as many as 1400 VHP working in 1000 villages.



## Presence Among the Poor



1. What is the name of the Organisation you are working in and what is the specific activity you are engaged in?

I belong to a group called 'PALMERA' (People's Action and Liberation Movement in East Ramnad) which started in 1978 by a group of Jesuits.

The women volunteers namely Sr. Clare ICM and myself entered in 1982 and hence at present this group consists of men and women from three different congregations viz Jesuits, ICMs and OSMs.

Our long-term goal is the overall structural change of the society or the total change. The immediate objective is

self-reliance (economically),

self-respect (socially) and

self-governing (politically).

For this purpose we have been organising the oppressed and the unorganised. As a result of the conclusions drawn by "the socio-economic and religious analysis of East Ramnad done in 1976 by a group of scholars headed by the famous sociologist Fr. Francois Houtart, our focus was on the Harijans who form 17.2% of the population according to the 1971 census. Starting from this sector, which was most oppressed





we were planning to move on to the other unorganised sectors too.

2. Your motivation and commitment to the poor is unique. Did you get it from your training in the medical college or from elsewhere?

Unfortunately I cannot give a positive response to this question. It is true that the college authorities used to stress the importance of reaching out to the poor but I could not see those values being practised concretely. To site an example, in those days our old students who came for holidays from posh hospitals in foreign countries were invited to give us talks and share their experiences. This naturally created in us a foretaste for studies in foreign countries. After being specialised in this manner how many of us could really afford to work among the poor today? How many of us are really doing?

My option for the poor comes from the realities which I faced. In 1976 when I visited Charles de Foucauld sisters in Madiwala (Bangalore). I was really touched by their presence among the poor. Their influence among the people was really great. Again when I started working in our hospital in Ramnad district, I used to visit the surrounding villages with my companions to have a knowledge about the people. The extent of discrimination and the inadequate response I could give to the reality of that time really made me feel guilty terribly. My presence as a routine medical officer in an institution was challenged.

3. What has contributed most to the development of your thinking in this line of approach as a Doctor?

Once again the realities that I faced in the hospital made me reflect on this line of approach. Since the hospital is situated near the villages I used to get all badly managed patients from the interior villages in critical conditions. The patients and their relatives used to be immensely happy once they are alright and we too as if we had done something very heroic. This reminds me of one of the crucial instances which made me reflect a lot.

A week after I joined the hospital I had a patient with eclampsia. She was from an interior village. When she was brought she was unconscious, had convulsion, about 38 week pregnant, oedemato's, her B.P. was about 210/140. There was no foetal heart sound, urine albumin — (actually one could put any number of pluses) My senior colleague (a male doctor who was working with me) and the administrator of the hospital who is also an experienced nurse suggested to me to refer the patient to a bigger hospital. As soon as the patient's mother sensed what we were planning she just held

on to my leg begging me not to send her anywhere else. She had no means to proceed further. She begged me to do what I could. The Study nurse who was a junior also encouraged me to start the treatment. I explained her condition to her mother and relatives and started the treatment. We tried our best and could save the mother. We could never forget the joy of those poor people. In this case, as all of us could see the toxemic stage could have been prevented had there been a medical person closer to the patient at an earlier stage. Sheer lack of medical knowledge brought her to this stage.

At another instance, one of our patients had to sell his cow to pay of his medical bill (that must have been the only sustenance!) All these instances made me reflect a lot and feel guilty for remaining in an institution where the needy lot couldn't reach in time or they could not afford to come at all.

In the initial stages I did have the feeling that my expertise as a medical person is underused but I never felt it irrelevant. After being with the people for sometime and knowing their economic, social and cultural background, I learnt to be relevant to the reality. In the beginning itself, if I start giving them the medical knowledge, as I received it, it would be like feeding someone with 'Biryani' when what he needs is only plain drinking water. So I learnt to wait.

5. Would you like to share your reflections with our readers, on your experience as a religious activist?

As a religious activist, I think I am privileged to play a role, rather share in the struggle of the oppressed. Two years back that is in June 1983 we participated in a protest rally against the court verdict regarding the murder of five Harijans. The issue at stake was the demand of the Hindu Harijans to have an equal participation in religious worship, which was denied to them for years. There were 86 people on the list of the accused but all of them were acquitted for lack of evidence. Our people knew that it was not the lack of evidence that gave a set back to them but lack of economic and political power to assert their rightful place in society.

During the whole rally and the public meeting I could see the joy of liberation on their faces. We were about 8000, 500 women and the rest were men. It was like the journey of the Isrealities to their Promised Land. The very presence of such a big gathering of people for the first time, in the history of Harijans in Ramnad district boosted their image up. My experience throughout was, as if I was taking part in the liberation struggle of the people who had lost their image. This



really deepened my vocation to work with the people. I am being constantly challenged by our own people who are ready to give up their own self and their family for the cause of justice. There are a few young men who even post-pone their marriage for the sake of their movement (People's movement).

Our community (team) consists of eight men and four women belonging to three different congregations, meet once a month to share, reflect and plan for the future; we are a strength to each other. Though at times there have been differences in perception, still it is not so much like the ordinary religious communities where we are often burdened with and weakened by trivial things. What binds us together is our mission to the people, what strengthens us is our solidarity in struggle with the poor.

6. What is the response and support you receive from your superiors? (Congregation/Diocese)

From the beginning itself I got positive signal from my Superior General and some of the counsellors. They were a real support to me. Of course I could not expect the same from everyone. Nowadays more and more of positive response and support I get from our young sisters and even from the elders. They gave me another sister after two years. This itself is a great support for me.

With regard to the Diocese, generally our work was not much appreciated by our former Archbishop. For reasons unknown to me and to our Superior General she was asked to take me away from the Team and the Diocese. Since he did not give any reason in writing as our Superior General requested, I continued my mission. Our team and the Congregation were with me during this time.

7. What are your suggestions for hospitals in the voluntary sector, especially those run by the Church to involve themselves in the people based health programmes?

Sometimes I really wonder whether we, the voluntary sector take the place of Government workers and fail to educate the people regarding their right to health. Often we say people are not satisfied with Government hospitals since they do not care much.

It is a question for me whether by our care and concern we have helped our people grow or whether we have perpetuated the present unjust health system in our country. For example we know the primary health centres do not have 100% coverage of immunization programme. To solve this problem, we buy the vaccines and keep them in our institutions and make them get it from us by spending from their

own pockets. . . . It is a national programme! So also the various educative programmes of the Government, the treatment of diarrhoea etc.

How much percent of our rural poor are aware of dehydration fluid? At least we who are supposed to be committed to the people, could fix up a target to make our people completely aware of the commonest illness. Perhaps we have to learn to see the problems little more critically and pool all our efforts together as one unified force instead of compartmentalizing.

So I think first and foremost we organise the people and give them the basic awareness that health is their right. This may sound that I am asking the medical person to become social activists. This is not. We need to become promoters of socially-oriented health programmes. This has to be the task of today and somehow it must be done. I think only then can we rightly call this as people based health programmes.

Secondly as we all stress so much to-day that health cannot be treated as an isolated entity, it has to be approached in its totality. So if we would work as small groups with committed socio-political activists then it will be viewed in its sociopolitical, economic and cultural perspective and then it will be really total health.

8. What is your message to your class-mates who are working in prestigious institutions today?

I am always proud of our college for the knowledge I received from committed professors and tutors. That gave me further urge to gain more and more knowledge. My conviction is that if I received more I have a greater responsibility and commitment to the people for whose sake I am imparted this knowledge or power. After being aware of the painful fact that after hundreds of years of hard labour and research we could eradicate only one single disease from the face of the earth and still if my classmates believe that they can contribute positively to our humanity (I mean the needy masses of our country) by continuing their work in prestigious institutions, I think that somewhere we have failed in our duty as committed promoters of health. Then I question as to whether we are in a better position than those who have taken up medicine as a commercial practice nowadays!

At the same time I do understand my friends. Since all of us are trained in a westernised way, it becomes really tough job to think creatively in our Indian situation and to make health more meaningful to our people. Still I think if all of us sincerely have a will to see a "healthy" India and are open to its implications, we can make this dream a reality.



9. What are your achievements, failures and insights in your present involvement; at the personal and work level?

The fact that the Harijan people (even women) could organise themselves, come together to discuss about their problems, learn to take decisions on issues and mobilise themselves for their rights — itself, I consider is a great achievement. We conduct a series of training programmes for cadres, leaders, and youth. On these occasions we give them some health message and the awareness that health is their right. I could say that only the seed is thrown (sown). we have to wait for its fruits.

The harijans in this area have a very long history of oppression and hence it takes equally longer time to come out of it. Any change or growth process is very slow in this area in particular. The caste feeling is so deep that it becomes harder for the people to think of joining with the other oppressed masses on class basis. But slowly there is an opening up among the cadres. In some of the areas the menfolk becomes a block for our work among women (from cultural point of view). They want their women to remain as traditional as before!

What I noticed among the harijans is that if they are little bit well off economically, their commitment to their community is less. They begin to isolate themselves from the others. So I think it is only those who are affected most come forward to join the struggle. Others only watch. Even among them the women are more militant than men. I think if they are given full freedom they will do more than men. I strongly believe if all the affected people, I mean the oppressed and the unorganised are organised and taught to see the realities of today in a critical way, they themselves will bring about a structural change and build a better India and better humanity.

## HERBAL POWER

The inhabitants of Puthurvayal and neighbouring area are — Tribals like Paniyas, Kurumas and Naikas and Mundadan Chettys who live there from time immemorial. The imigrant farmers from the District of Kerala — comprising Muslims, Christians and Hindus and lately Tamil repatriates from Sri Lanka. The mission station was established in 1969 and it became a parish in 1972.

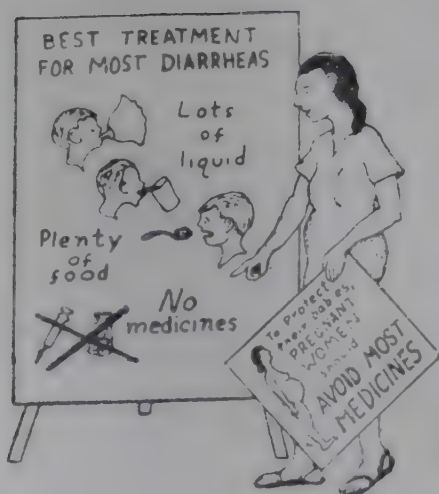
Though there was the Taluk hospital in Upper Gudalur 6 Kms. away for ordinary ailments the people resorted to their own health practices, and traditional medicine — with a mixture of magical and superstitious, practices.

The most common diseases found in the area were gastro enteritis, diarrhoea, dysentery, scaris, rheumatism, Ashtma etc.

Before Vimala Rural Health Centre was started, Sr. Innocent used to visit this place from Beeki, and conducted clinics. In 1981 Vimala Rural Health Centre was started with Mother & Child Health classes for women etc. There was special emphasis for Tribal conscientisation work and health classes for women. These classes were conducted in their own hamlets with the neighbours. The work here was much appreciated by the Diocesan social Service Centre and Rural Health Programme. So that they used to send trainees who came there for field work to Puthurvayal.

Sr. Innocent comes from a family which practiced Ayurvedic medicine and especially the diseases of the eyes and stomach but lately this practice was neglected as the members opted modern studies. Sr. Innocent herself is qualified as a Laboratory Technician, But for several years she had to work in the different capacities in rural hospitals and health centres.

In Nilgiri District of Tamil nadu she first worked in Beeki in a Rural Health Centre. When she had close contact with the tribals — and found to her great surprise that several superstitious practices really took away many lives.





Her service was requested by different mission stations ; so she visited these stations once in a fortnight or once a week.

So when Vimala Rural Health Centre was started at Puthurvayal she was already a known person there.

Puthurvayal is close to the forest, so there is no dearth for medicinal herbs.

With more and more exposed to the drug problems, the present health delivery systems, inaccessibility of the poor patients to the government and private health care institutions and the experiences of the herbal treatment gave more and more leaning to adopt herbal medicine. At first Dechanes Herbo mineral medicines were made use of — and even now they are not all together discarded.

#### **Factors inducing herbal treatment :**

With the background she had at home and from what she had learnt from the tribals she had herbal alternatives for drugs for many cases.

The Rural Health Programme of Wynad Social Service Society and the Mother and Child health education programme, requested her service for giving classes and sharing of experiences for Village Health Worker's Mother and Child Health Aides and lady animators. This required more study and sharing for herself. Bishop Dr. Jacob Thoomkuzhi encouraged her work.

At this point she got in touch with Deenabandhu, RK Pet and she spent 6 weeks at the Health Workers leadership Course in 1983 and this gave additional experience and courage.

Now she is called on by many for giving classes for Village Health Worker's in different diocese. Rather than abstract theories she shares her experiences with herbs and this is found very useful by the participants of her classes.

#### **Puthurvayal**

As mentioned above Puthurvayal was a real "Rural" centre with only primitive accommodation for the inmates and for the occasional 'trainee' and their work also was among the tribals and the poor farmers who could not afford the modern health care of the town.

When a patient reports together with medicine he or she is entertained with a conversation which is a very personal "health Class". This often gives information regarding what they tried before and its effect. The patient is encouraged to continue what was successful. Herbal medicine is suggested and if they do not know the plants, the plants are shown to them and in some cases medicines are prepared and administered. (When necessary herbal products of companies are also given). This was a mutual learning.

### **Herbal garden**

Many plants used for common ailments are grown here. Some plants which are not common in this area are planted here. Another important need for herbal garden was to show it to the patient, when the patient cannot identify the plant with the name. Now there is a modest herbal garden around the Rural Health Centre. But still we depend merely on the plants which grow wild outside the compound. We can be proud that many people have collected seeds and saplings of plants for their garden.

### **Seminars and Classes**

Two groups doing health work elsewhere have come to Puthurvayal for observation and classes. They stayed three days and have benefitted from the sharing. Dr. Hari and Dr. Prem John from Deenabandhu came here to facilitate a seminar on Herbal medicine for our co-workers from Kerala and Karnataka. This group has evolved as more or less permanent group.

### **Request for classes**

Request from other voluntary groups for classes is really encouraging in the sense that it is a recognition of our work. But unfortunately the Rural Health Centre most of the time works as a "One man army". The Village Health Worker's are in the village and there are only two sisters in the Rural Health Centre. So inspite of our goodwill we had to disappoint many. As far as possible we try to take up requests from seminars for Village Health Workers.

### **Learning More**

Learning from the patients, learning from different tribals and consulting more with others instructed in the herbal treatment increased our knowledge. There were several seminars and exhibitions of the medicinal herbs conducted in different parts of the country (to our surprise some of these exhibitions were conducted by groups with financial interests).

### **CHAI Exhibition**

The theme of the Catholic Hospital Association of India convention, November 1984, Bangalore was towards a



people oriented drug policy. Herbal and Home remedies were considered as a people oriented alternative. So we accepted the Catholic Hospital Association of India invitation to put up a stall of medicinal plants. This gave us publicity, perhaps a little more than we deserved. At present the Vimala Rural Health Centre continues its modest work, though Sr. Innocent is not there.

## **A few case histories**

Herbs, being the base of most medical preparations can be administered in simple methods. Moreover, fresh herbs without the admixture of other ingredients work better. Herbal treatment can even take care of emergencies. It is effective for many chronic diseases.

### **Sinusitis**

A man 28 year old had acute sinusitis for 8 years. He had treatment from several doctors; but only momentary relief. The doctors suggested operation but he was afraid. In the 8th year he also had wheezing. He could not sleep. Avil, 25mg and betalam Tab-I was his night routine before sleep. This will give him a few hours of sleep.

He came for herbal treatment. He took a preparation of 1 teaspoon full of turmeric powder and 7 grams of black pepper boiled in diluted milk. He also applied the oil boiled with Tulsi leaves. Within 3 weeks his headache, sneezing and wheezing disappeared. It is one year now. The symptoms have not reappeared.

### **Peptic Ulcer**

A 47 year old, man working in Bombay had peptic ulcer. He was suffering for the last 17 years. He consulted several doctors and the treatment was not successful. FTM Test in a reputed hospital was followed by an operation. But the condition was worse. He vomited frequently and could not digest food. His relatives consulted us for some temporary relief. Herbal medicine was suggested, but the patient refused to take it, so he was given antacid tablets. But eventually he agreed to try herbal.

Turmeric powder soaked in honey 3 times a day. In 3 days he could digest milk. In the next two weeks he could eat soft food like rice. Then he took solid food. With 3 months treatment he received, can eat any food now.

A 33 year old woman suffering from leukaemia and excessive bleeding, had undergone several treatments for the last seven years. Finally she had penicillin injection. This too gave only temporary relief

She was very much disappointed. She was asked to take 'Nilappana' in milk. In a week she had marked improvement. In three weeks the discharge disappeared. For severe menstrual pains and irregular periods she took the flower and flower buds of hibiscus. She has reported complete cure.

We can narrate any number of cases successfully treated with simple herbs. But this is not necessary. We failed the successful of the treatment in a different way.

*Patients come more for reporting than consulting.* Now very few people come without first trying something for their illness. They report progress or otherwise and consult for further treatment.

### Home remedies are given to family members and drug neighbours

Now those who have tried home remedies and those helpful neighbours who are frequently called upon by others when in need give the same during for others. Sometimes there can be misinformation too. We used to give a plant 'Muyal cheviyan', for painful throat and tonsillitis for external application. A Sri Lanka repatriate had cough and cold. He was asked by a neighbour to apply this medicine. There was the language barrier. The sign language was understood that it was to be taken orally. He followed and it caused several problems. Of course this practice can have its problems.

### Herbal garden

Now we see a respectable position accorded for herbs like tulsi, Arutha, etc, in many homes and several herbs grown naturally are now protected. People have become herb-minded. Some keep medicinal plants in their vegetable garden.

### Enemies of Science

Recently we are facing a charge of being 'enemies' of science. Many of our friends ask "Do you want to go back to the bullock cart" "age from the space-age." We are considered witch doctors to try herbs in this advanced age of Science which has ready cure for all illness.

### We are sorry for our sins

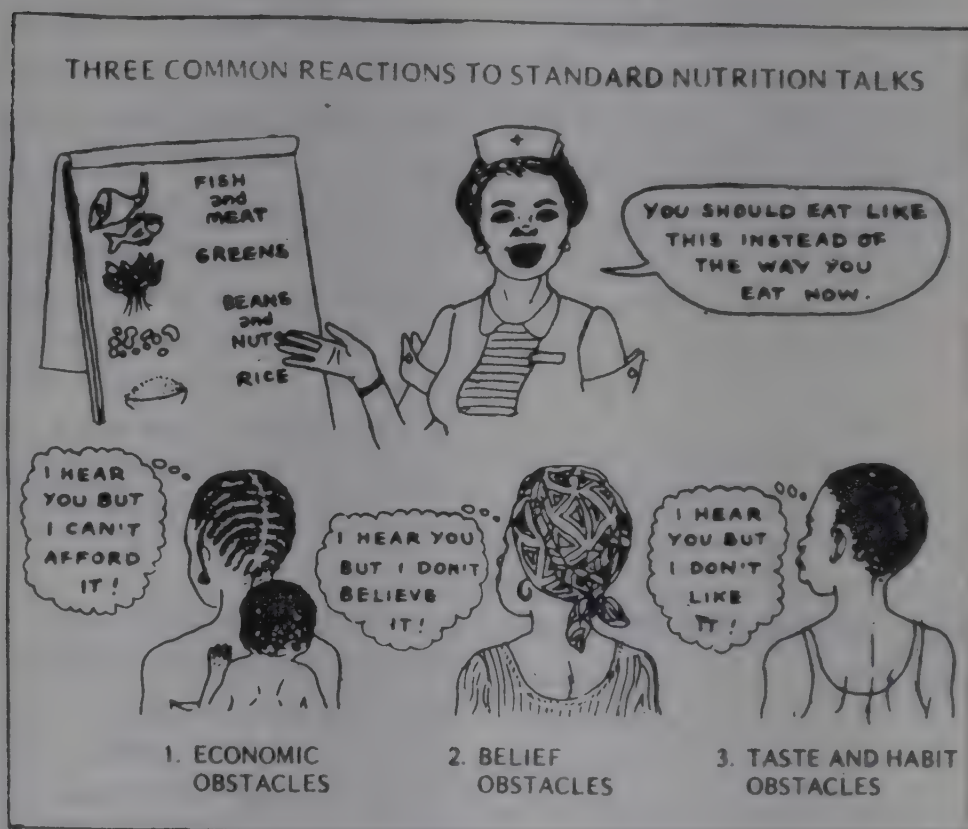
We would like to confess a "Serious sin" we have committed and which we have not completely atoned for. We know many others fall into the same 'sin'.

In giving health education to the tribals we have persuaded them to change many of the practices which we now know, are very reasonable. They used fresh bamboo knives



to cut the umbilical cord. The mother and the baby are kept in dry hay. The grannies used to keep bundles of dry hay if a lady is pregnant at home. We discouraged these practices as primitive and superstitious. The poor tribals do not have enough money to provide warm clothes for the mother and the baby and they have abandoned the practice of keeping hay.

The kind of nutrition education that Puthurvayal does not need.



There is another sin more serious than this. We had given them "free medicine". Aspirin-vitamins and other tablets which the govt. gave us free or even from our own pockets. Now they have not only discarded their herbs, but consider it out of fashion to use. They want tablets and injections. Now when we suggest herbs they ask Do you think we cannot afford to pay? *We shall give them tablets.* It is hard to re educate them about herbs. We request our readers not to commit the same sin. Please try to study more about a practice before you condemn it.

The good thing we find about the reaction of the people is — they are more self dependent and willing to help others— and willing to learn more. This helps our health education.

# Philippines

## Basic Communities at health work

Fr Thomas Joseph is coordinator of Community Health and Development Team. He recently spent a month in the Philippines, studying community based health programmes.

Philippines is one of the south Asian countries spread over seven thousand one hundred and eight islands. For the last four hundred years, the destiny of its people were by and large determined and controlled by western powers. Centuries of continued foreign domination has left the country and its present fifty four million population in a state of poverty, misery and illhealth. As people began to become critically aware of their plight, and eventually emerge with new determination, President Marcos declared martial law in 1972, in connivance with and under the pressure of the United States. Ever since, Marcos remained a puppet in the hands of the American Imperialist forces and hardly paid any attention to the welfare of the Philippines.

### New Challenges for the church

The worsening socio political situations coupled with the economic deterioration and high rate of inflation due to the haphazard policies of the US-Marcos dictatorship further aggravated the plight of the poor, especially in the urban slums and the rural areas of the country. The explosive situation thus emerged in the early seventies, started disturbing and challenging few of the church leaders in the country, which has 95% Christian population. The teachings of II Vatican Council and the emergence of Liberation theology inspired them further to question the role of the Church and its Social relevance in the Philippines context.

The inadequate and miserably inefficient government health infrastructure in the country vis a vis the distressing health situation of the poor, exploited and oppressed little people, compelled different groups to start questioning the existing approaches to healthcare, in order to look for new ways to respond to the prevailing situation. Even today 62/100 did in the country without any medical help. This situation is still getting further depressing, as Philippines continues to be the world's number one exporter of nurses and number two exporter of doctors. (Ironically India is the world's number one exporter of Doctors and number two exporter of Nurses!) Pneumonia, T.B. and upper respi-



ratory diseases are the major killer diseases in the Philippines. However, ever since the proclamation of martial law in 1972, militarisation and US imperialism has become the major killer disease that disables millions and kills thousands in the Philippines! The soul searching reflections among serious groups that ensued, finally paved the way for the community Based health programmes (CBHP) in the Philippines.

### **The pioneers**

The group responsible for initiating and moulding the CBHP as it exists today, is the Rural missionaries of the Philippines (RMP), an inter congregational group of Catholic women religious with the support of their major superiors. A background information of the formation and development of the RMP will serve as a basis for better understanding of the CBHP.

The depressing socio economic situations and the growing miseries of the Philipinos on the one hand and the concentration of 1/3 of the total women religious in the capital of the country on the other made it imperative for the people in the Catholic Church organisation NASSA (National Secretariate of Social Actions) to take a critical look at the way the church was responding to the cries of the people. This process finally led Bishop Lebayon, the then National Director of NASSA to request the Association of Major Religious Superiors of Women (AMRSWP) to release sisters for rural Apostolate. Thus in August 15, 1969, the RMP came to exist, with 19 sisters from seven congregations. Ever since its formation, the RMP underwent through process of evaluation within its own membership, organisation, ideology and strategies. Today, there are 74 Rural Missionary Sisters belonging to 14 congregations, and their work is extended to 27 Dioceses all over the Philippines. Three priests from two congregations and one brother from OFM are also members of RMP today.

### **Towards a programme :**

The inspirations from the Holy Bible and the Vatican II documents were the motivational force behind the CBHP, which had its beginning in 1974, in the outskirts of Manila city in an urban setting. Initially it was a para medical workers' training, with hardly any structural analysis. The programme was extended to rural areas in 1975, starting with three pilot projects in Luzon, Visayas and Mindanao.

In 1978, a joint consultation of people involved in CBHP, and committed medical professionals was held, and the structural analysis of the society in relation to the illhealth of the society in relation to the illhealth of the people was done for the first time, and ever since the programme was named as CBHP, incorporating significant thrust on community organisation. This new thrust was a national outcome of the critical analysis of the glaring contradictions experienced in the field. It was indeed a difficult process, especially for health professionals to accept the fact that, all the wonders of modern medical science and technology were of no use in coping up with the root causes of health problems — economic, social, political and cultural. 'Antibiotics could kill germs; but what could it do for malnutrition and institutionalised poverty?' This rude awakening catalysed an understanding that health problems, would need to be solved through people's organisations. This necessarily implies the active participation of the people at all levels and stages of the programme. This understanding was based also on the learnings from social investigation obtained through social immersion (living with people and sharing their lives) with the target population which resulted in raising one's consciousness and sharpening of perceptions.

### **Shift from the tradition**

The CBHP recognises the fact that the health problems of the community are inter related with the economic, social, political and cultural problems of the society. Health is seen as only one component of the overall development of the community. The people are enabled to see that their health problems are related to food production and distribution problems, nutrition, water supply, housing, education, income distribution, employment, communications, transport and ultimately to political decisions. The total well being of the community and its people is the ultimate aim.

The rural missionaries have differentiated community based programmes from community oriented programmes. For them, community oriented programmes are essentially hospital based and doctor administered. Here, activities and decisions are dominated by the professionals and the role of the people is very passive. This will ultimately create dependency in the people, and is detrimental to their true development. On the contrary, in a community based programme, the initial goals, objectives and planning are open-ended and flexible. These consider the community's felt needs and not



the needs as felt by the health professionals. Here the programme personnel try to inspire, advise, motivate and demonstrate, and do not make decisions for the community. The community is strongly involved in all areas where decision making is needed. Community based health programmes are therefore built from the grass roots up and not given from the professional or institution down to peoples.

### **How do they go about**

Initially, the CBHP was started, with the formation of a mobile health team moving around the country, to train Community Health Workers (CHW's). But the years of experience in the field has brought about a radical change in the thrust as well as the strategy of organising and extending the programme to other areas. Instead of a centralised training as in the beginning stage of CBHP, today the RMP have devised different steps at different levels for the training and extension of the programme.

Once the area of involvement is identified by the RMP, an initial study and social investigation of the area is done. Then the local parish is contacted. It is the parish that contacts the village assembly and make arrangements for the RMP to explain the programme to the people. After this the villagers are left to themselves for a period of time for internal discussion and decision as to whether they need health programme in their village. If they are interested, the people themselves select the candidates for CHW training and request the RMP to train them. Then the training is taken up by the sisters in the village itself, where the selected candidates are gathered. Steps are also taken to orient the entire village, and a health committee is formed in the village to monitor and assist the CHW's to carry out the programme. Wherever there is a health ministry committee in the parish council, they are also trained as middle level workers by the RMP.

The training itself is a community activity. Curriculum planning is based on the trainee's own community survey and their own assessment of the needs of the community. Traditional beliefs and practices are integrated. The potential good or harm of these traditions are analysed by the radical departure from the earlier approaches which depended on an importance of health skills and knowledge, without due recognition of the community's own needs, resources and beliefs.

The duration of the training is normally one year; and it is conducted on weekends when the people are free. As mentioned the syllabus, the topics of the training are kept very flexible and the health skills related to the pressing needs and health problems of the people are always given priority. This approach has boosted the enthusiasm and the interest of the community, as well as that of the CHW, since they could become programme right at the start of programme itself.

### **A relevant training**

At the initial stage of the training itself, the CHW's enabled to do research into the traditional medicines of the people, and to collect as much information as possible from the people themselves. This is followed up by the efforts of the programme to give scientific explanation and meaning to the different practices of the people and also to remove the magical aspects. During the training programmes, the traditional healer's in the villages are invited to share their experiences with the CHW. This has helped to ensure mutual collaboration, avoiding possible antagonism between them. By and large the training programme helps the people to understand their history, to accept their culture, and to be proud of themselves. This approach of starting off the programme from where the people are, served as a spring board for the CBHP and the related activities in the area.

In the beginning of the CBHP programme, the CHW's were given a medical kit by the project, but it has been discontinued now, because of the attitudinal changes observed in them and their emergence as elite class and mini doctors! However the CHW's keep few western medicines with them, though the bulk of the medicines with them though the bulk of the medicines they use are herbal ones. Community herbal gardens are also promoted. All the CHW's are trained in accupressure, and some are trained in Accupuncture. The activities of the CHW's include systematic immunization programmes, health education programmes, Anti — T.B. programmes, Dais work, MCH, house visits etc. In those areas where the CBHP is linked with a hospital, the CHW's refer the patients, to the hospital on particular days, and the doctor recognizes and upgrades the skills of the CHW through his/her participation with the doctor in the diagnosis of the patient. This increases the morale of the CHW on the one hand and the confidence of the people in the CHW, on the other.



## **Service is voluntary :**

The CHW's in the CBHP are not given any monetary remuneration, even though the government health workers are paid. But the programme has developed other mechanisms to encourage and support the volunteers eg. the CHW day celebration, which is marked by sharing, reflection, evaluation, conscientisation programmes, slide shows etc. Also from among themselves coordinators are selected and they organise their own monthly meetings in each area. When there are full time co-ordinators or when a co-ordinator is assigned duties outside his/her own area, they are paid a honorarium by the project. Sometimes the CHW's receive donations from the people, but the amount is put in a common fund to be used for common activities in the village or for the purchase of simple equipments like thermometers, BP apparatus, stethoscope etc. Also a mutual support system is developed among the CHW's at the village level, where they consult each other and refer patients to those CHW's with more skills. In certain areas, the CHW's are formed into associations with legal status to check the constant harassment from military and police.

Since the training of the CHW's are decentralised and are done at the village itself, the expenses are considerably low. Most of the provisions for the CHW training and their Diocesan or regional meetings are met by the participants themselves in cash or in kind. Those areas where the foreign Missionaries were involved with the dolling approach, the CBHP had a hard time, compared to those places where the programme could be launched on a clean slate.

The enthusiasm, seriousness and the commitment of the CHW's is inspiring, and undoubtedly it is no less than the RMP, who are the motivating and driving force behind the programme.

## **CBHP as a movement in the Philippines**

CBHP was a natural outcome of the Christian response that the Philippines' church made to the distressing health situation of the poor in the urban squatters and the God-forsaken rural areas. The hopelessly disorganised and inadequately financed government health programmes had lost all its relevance to these people. Nevertheless, the initiatives and the experiment of the RMP brought in a ray of hope in this dim situation, and it was well picked up by other voluntary organisations in the country.

There are mainly two types of organisations in the non governmental health sector. They are (1) service type orga-

nisation, and (2) organising type organisations. Three national organisations fall in the former category. They are :

1. Rural missionaries of the Philippines (RMP) ; which gave birth to CBHP, and also today coordinates the Catholic Church's initiatives in CBHP.
2. National Ecumenical Health Concern Committee (NEHCC) ; which functions under the National council of churches in the Philippines, and is the protestant counterpart to RMP, co-ordinating programmes in their religious sector.
3. Council for primary Health care (CPHC) ; which is a non sectarian organisation, assisting and co-ordinating service organisations through training, research, publications etc.

These and other regional and smaller organisations contributed a great extent towards the spreading of their vision and approach throughout the Philippines. The major factors that facilitated this movement are :

- critical understanding of the socio-political factors affecting health proved the futility of institutional health care, for many non governmental organisations in the health sector, for whom the well being of the people mattered.
- The institutional support which the RMP enjoyed from the major religious superiors, and their respective congregations, to make experiments, as well as the relatively independent character of the RMP, along with their functional links with individuals and groups.
- An ongoing critical reflection on their charism by different congregations against the Philippines milieu, initiated by NASSA, as well as the emergence of the theology of liberation in the country.
- The growing number of Basic Christian communities in the countryside and the links the RMP enjoyed with them.
- The contacts of the RMP with the academic institutions, like medical colleges, Nurses training centres, and the involvement of Medical professional in the CBHP.



- The ecumenical character of the Church in the Philippines, and the collaboration between catholic and protestant organizations at different levels, and the unireligious character of the country.
- Regular and ongoing reflection and consultation on CBHP with different organisations, groups and individuals involved in health, through which many were brought into the main stream of CBHP approach.
- The co-ordinating role played by the CPHC in promoting CBHP approach in service organisations.
- The involvement of the RMP in other sectoral movements like peasants, fisherfolk, tribals, youth, women etc.
- The process oriented, rather than target oriented approach of the CBHP.
- Less involvement of the outside money and reliance of the programme on the people and the local resources eg. Herbal medicines, Accupressure etc, and the voluntary service of the CHW's.
- The direct introduction of the programme to the people, rather than the mediation of institutionalised health institutions, and the minimum administrative structure.

There could be many more causative factors that made community health a countrywide movement in the Philippines. Today, by and large individuals and groups involved in building a healthy community in the philippines follow the CBHP methodology which is a proven approach in the Philippines context.

### **Conclusion**

The CBHP experience of the Philippines has begun crossing the shores of the great, but ruthlessly crippled nation, to other Third World countries too. Our country has got a lot to learn and get inspired from them, as the social economic, and political situation in both these countries (except the martial law and the continuing militerisation in the Philippines) manifested in the situation of the peasants, agricultural labourers, industrial workers, slum dwellers, tribals, harijans, fishermen, the plight of children and the exploita-

tion of women etc. clearly indicates that the experience of the Philippines has got great relevance to the Indian context.

'What unites us today is a common understanding of the structural causes of the health problems, and the commitment to certain principles which forms the basis for our methodologies. As health personnel we need to do our share in transforming the health system, without losing sight of the broader structures that determine and re-inforce that health system.



This is a scene from a 'Farmworkers' Theater' production in Ajoya, Mexico. It was presented to help villagers recognize the differences between a good health worker and the typical doctor.



## Setting Community Priorities

Mark your answers with pluses (+++++) on a blackboard or a sheet of paper.

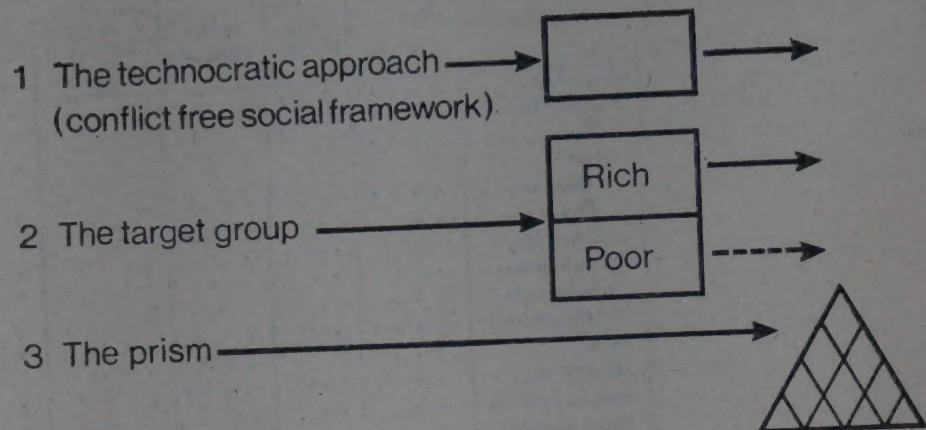
| PROBLEM            | HOW COMMON | HOW SERIOUS | PEOPLE'S CONCERN | HOW MUCH IT AFFECTS OTHER HEALTH PROBLEMS | POSSIBILITY FOR TEACHING PREVENTION OR TREATMENT | HOW MUCH CHW COULD DO ABOUT IT IF TAUGHT | IMPORTANCE TO BE GIVEN IN COURSE |
|--------------------|------------|-------------|------------------|-------------------------------------------|--------------------------------------------------|------------------------------------------|----------------------------------|
| Diarrhea           | ++++       | ++++        | +++              | ++                                        | ++++                                             | ++++                                     | 21                               |
| Malnutrition       | ++++       | +++         | ++               | ++++                                      | ++++                                             | ++++                                     | 21                               |
| Worms              | +++        | ++          | ++++             | ++                                        | ++++                                             | ++++                                     | 20                               |
| Cough              |            |             |                  |                                           |                                                  |                                          |                                  |
| Common Cold        | ++++       | +           | ++++             | +                                         | ++                                               | ++                                       | 14                               |
| Pneumonia          | ++         | +++         | ++               | ++                                        | +++                                              | ++++                                     | 16                               |
| Tuberculosis       | ++         | ++++        | +++              | ++                                        | ++++                                             | ++++                                     | 20                               |
| Skin Diseases      | +++        | +           | +++              | +                                         | +++                                              | ++++                                     | 15                               |
| Stomachache        | +++        | ++          | +++              | +                                         | ++                                               | +++                                      | 14                               |
| Tooth problems     | +++        | +           | +                | +++                                       | +++                                              | ++++                                     | 15                               |
| Fever              | +++        | ++          | +++              | +++                                       | +++                                              | ++++                                     | 19                               |
| Drunkenness        | ++         | +++         | ++++             | +++                                       | +                                                | +                                        | 15                               |
| Pregnancy & Birth  | ++         | ++          | ++               | ++++                                      | +++                                              | ++++                                     | 17                               |
| Heart Attack       | +          | ++          | ++               | +                                         | ++                                               | +                                        | 9                                |
| Epilepsy           | +          | ++          | +                | +                                         | ++                                               | +                                        | 8                                |
| Bottle Feeding     | +++        | +++         | +                | +++                                       | ++++                                             | +++                                      | 18                               |
| Tetanus            | +          | ++++        | +++              | +                                         | ++++                                             | ++                                       | 15                               |
| Headache           | +++        | +           | +                | +                                         | ++                                               | +                                        | 9                                |
| Misuse of medicine | ++++       | +++         | 0                | +++                                       | ++++                                             | ++                                       | 16                               |
| Land tenure        | ++++       | ++++        | ++++             | +++                                       | +++                                              | ?                                        | 21                               |
| Accidents          | ++         | +++         | +++              | ++                                        | +++                                              | +++                                      | 16                               |
| Vaginal Problems   | +++        | +           | ++               | ++                                        | +++                                              | +++                                      | 14                               |
| Measles            | ++         | +++         | ++               | ++                                        | +++                                              | +++                                      | 17                               |
| Whooping Cough     | ++         | +++         | +++              | ++                                        | +++                                              | +++                                      | 16                               |

Source: H.H.W.L.



# Project designing

## A The conventional approach



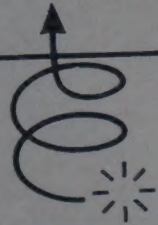
## B The new

### 1 Understanding the contradiction tree/ PRISM

|      |                                        |       |          |       |       |          |
|------|----------------------------------------|-------|----------|-------|-------|----------|
| Rich | Landlord Moneylender Trader Bureaucrat |       |          |       |       |          |
| Poor | Men                                    | Women | Landless | Caste | Young | Religion |

### 2 Training of committed village cadres for initiating (and multiplication) of activities

### 3 Building organizations of the poor

|                   |                                                                                       |  |      |
|-------------------|---------------------------------------------------------------------------------------|--|------|
| Self-reliant base |  |  |      |
| Staging           |                                                                                       |  |      |
| Initial activity  | Material benefit                                                                      |  | Mind |

### 4 Strengthening critical institutions

- a Village forum assembly
- b Village organisations: women's groups, youth groups, landless labour etc.
- c Village fund





